IN THE CIRCUIT COURT OF DESOTO COUNTY, MISSISSIPPI

KAY T. NUNNALLY, INDIVIDUALLY
AND ON BEHALF OF ALL WRONGFUL
DEATH BENEFICIARIES OF JOSEPH
LEE NUNNALLY, DECEASED — PLAINTIFF

V. — CIVIL ACTION NO. CV92-270-CD

R. J. REYNOLDS TOBACCO
COMPANY AND BASIC FOODS, INC. — DEFENDANTS

VOLUME 9
DAILY COPY TRIAL PROCEEDINGS

DATE: July 7, 2000

APPEARANCES:

CHARLES MERKEL, ESQ.
JACK R. DODSON, JR., ESQ.
Merkel & Cocke
COUNSEL FOR PLAINTIFF

MICHAEL W. ULMER, ESQ.
LEWIS BELL, ESQ.
Watkins & Eager

WILLIAM H. LISTON, ESQ.
Liston & Lancaster
JOSEPH M. DAVID, JR., ESQ.
Jones, Day
COUNSEL FOR DEFENDANTS

REPORTED BY: Ginger H. Brooks
RPR, CSR - MS, TX, OK, #1165
Brooks Court Reporting, Inc.

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JUDGE CARLSON: We should have water for the next few minutes, anyway. The water cut on. The pressure is building back up.

(Jury enters courtroom.)

JUDGE CARLSON: All right. Ladies and gentlemen. We're ready to go. The delay was caused by me. I was talking to the contractor trying to find out about the water. Quite frankly, I don't know whether or not all of you were able to get into the restroom since there's no water pressure to be able to flush the commode. So if you need a break quicker than normal, just let me know, and we'll stop at any time, and hopefully by that time, the pressure will be back. The contractor told me, it's been at least five minutes since I talked to him.

They have to cut the water back on gradually and he thought it would take another 15 or 20 minutes for the pressure to build up sufficiently. So somewhere along the way if you need a break before the normal time, just get my attention, we can do that.

Since you've had the overnight recess, I need to find out if you've had occasion to talk with anyone about the case, or has there been any effort on the part of anyone to talk to you about the case,

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any outside information gained about the case, anything you need to bring to my attention?

I take it there's been no contact or discussion. We'll move forward at this time. Mr. Liston.

MR. LISTON: We'd like to call a Mr. Guyton Nunnally, please. Your Honor, Mr. Nunnally is the brother of the decedent, and we'd like to call him in an adverse posture.

JUDGE CARLSON: All right. You can come around and let the clerk swear you in.

GUYTON NUNNALLY,

having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION BY MR. LISTON:

Q. How are you, Mr. Nunnally?

A. I'm fine.

Q. My name is Bill Liston. I don't believe we've met before right now, have we?

A. That's true.

Q. All right, sir. I'm going to be asking you some questions this morning, and your deposition

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was previously taken in this case; is that correct?
A. That's correct.
Q. I have a copy of it. If at any time you

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need to refresh your recollection about events or things that were asked you in that deposition, let me know, and I can give you a copy of the deposition.
A. All right, thank you.
Q. All right, sir. Thank you. Would you state your full name, please, sir?
A. James Guyton Nunnally, III.
Q. What's your date of birth, Mr. Nunnally?
A. March 27th, 1948.
Q. Where do you presently live?
A. [DELETED].
Q. And what is your job or occupation?
A. I'm the sales manager for a photographic and digital imaging company in Memphis.
Q. What was your relationship to Mrs. Marion Nunnally and James C. Nunnally, Jr.?
A. James C. or James G.?
Q. James G., excuse me, you're right.
A. I'm their oldest son.
Q. And your father, James G., is deceased; is that correct?
A. That's correct.
Q. When did he die, Mr. Nunnally?
A. Last year, July of last year.

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Q. And your mother, Mrs. Marion Nunnally, is still living?
A. That's correct.
Q. You were the oldest child of that family, I believe; is that correct?
A. That is right.
Q. And you were born in 1948?
A. That's correct.
Q. And Ben, your next brother, was born in 1950; is that correct?
A. I believe that's correct, yes.
Q. And Mr. Joseph Nunnally was born in 1952?
A. Uh-huh, June.
Q. Two years separated each one of you?
A. That's correct.
Q. Is that correct?
A. Uh-huh, uh-huh.
Q. Where did you attend elementary school, Mr. Nunnally?
A. Well, prior to moving to Horn Lake in 1959, I went to elementary school in Memphis, Longview Heights, but I started the 6th -- 6th grade at Horn Lake in '59, I believe.
Q. And that's when your family moved from Memphis to [DELETED]?

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A. That's right, that's right, Horn Lake.
Q. Horn Lake, excuse me. Did Ben and Joe eventually attend the same school that you attended?
A. Right, that's correct.
Q. If you were in the 6th grade when you moved, then Ben -- both Ben and Joe would have been in the school when you moved down here --

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A. That's correct.
Q. -- is that correct? You lived with your parents from the time here in Horn Lake, you lived with your parents from the time you moved until you graduated high school?
A. That's correct.
Q. What year did you graduate high school?
A. In 1966.
Q. And all that time, Ben -- that chair is a little tricky there. All that time, Ben and Joe were attending Horn Lake High School or -- Elementary School or high school, correct?
A. That's right.
Q. What was the first time that you saw your brother, Joe, smoking a situating cigarette, Mr. Nunnally? About what age? I'm not talking about a date.
A. 15, 16, in that age.

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Q. I believe you testified that you never saw Joe smoke a cigarette at any time before the time that you've just told us; is that correct?
A. Not that I can recall, that's correct.
Q. All right, sir. After you graduated from high school, you were actually absent from the family home for quite some time, were you not?
A. Basically, that's true, yes.
Q. And when did you -- I know that you moved to Florida, and then you were in the service?
A. That's correct.
Q. And then, eventually, you came back to Mississippi?
A. That's right, uh-huh.
Q. About 1980?
A. Well, if you're talking that little time frame, I really came back after -- after the Navy, which was about 1971, '72, stayed for a while. We moved to Atlanta, and we came back to Atlanta in about 1980.
Q. And when you came back from Florida, you lived at home for a while and attended Northwest Community College?
A. That's correct.
Q. Was Joe living at home then?

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A. I believe so, yeah.
Q. And how long did you live at your home during that period of time?
A. Not -- not very long. We had a fairly small home, and it was a little crowded.
Q. As I understand your testimony, during the period of time that you were in high school or elementary school from the time that you moved back here to Memphis with your family, you lived in the home with your brother, Joseph; is that correct, up until you graduated from high school?
A. Yes, uh-huh.
Q. Which was 1966.
A. That's right.
Q. And during that period of time, you never saw Joseph smoke a cigarette, did you?
A. I don't recall seeing him smoke a cigarette.

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Q. Do you recall telling us in your deposition that you did not see him smoke a cigarette?
A. Yeah, I read the deposition a couple of times, and that's what I did say, you know.
Q. And that the first time that you did see him smoke a cigarette was when he was about 15 years

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age -- of age?
A. Is that what I said in the deposition?
Q. After you came back in the '80s, would you describe your relationship with your brother, Joseph?
A. Well, it was -- it was more of a friendship relationship than I think brothers, because we had been apart such a long time. We just kind of made a new friendship at that time.
Q. And I believe you characterize it as, really, you had the opportunity to become closer to him during this period of time than you ever had before that?
A. That's right, that's right.
Q. From 1980 up until his unfortunate death, Mr. Nunnally, you were in a position to -- because you were closer to him, to know him pretty well as a person, is that -- is that a fair statement?
A. Well, I knew him more as a person than I had at a previous time.
Q. How would you describe Joe's attitude toward personal responsibility during that period of time?
A. I would -- I would say that he took his personal responsibility very seriously.

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Q. Would you say that he took responsibility for his own actions?
A. Yes.
Q. Was he a determined, strong-willed person during this period of his life?
A. Yes.
Q. I believe you told us previously that Joe was the type person that if he put his mind to something, he could pretty well do it; is that correct?
A. That's right.
Q. Is that a fair --
A. That's a fair assessment.
Q. -- statement about Joe?
A. Yes.
Q. When you were living in the home, would you tell us what your mother and father's smoking practices were? Did they smoke?
A. Yes, they smoked.
Q. Did your father, to your knowledge, ever quit smoking cigarettes?
A. Yes, he did quit, uh-huh.
Q. And when was that?
A. I think he was probably late 50s, early 60s, his age.

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Q. That would have been in the '80s or earlier than that?
A. It could be earlier than that. I can't

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really do the arithmetic in my head right now.
Q. That's fine. As you recall, with his he able to quit, what we say "cold turkey"?
A. No, he was not able to quit cold turkey.
Q. Tell us about how he managed to quit.
A. Well, it was the a struggle for him, because he had smoked all of his life. And he had smoked very heavy cigarettes, Camels, unfiltered.
Q. Did he have to seek professional advice, or did he do it on his own?
A. Not that I know of. I think he did it on his own.
Q. Do you know whether or not he had to resort to nicotine patches, or nicotine gum, anything like that in order to stop smoking?
A. Again, I'm not -- I'm not sure. I don't -- I don't know.
Q. Your mother was a smoker also, I believe you had told us.
A. That's correct.
Q. And she quit also, didn't she, Mr. Nunnally?

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A. Yes.
Q. Did she quit, just cut it off and stop?
A. I would say that she had an easier time of it than my father did.
Q. And I'll ask you the same questions about what she did to stop smoking. Did she have to seek professional help to do that?
A. Not that I know of.
Q. Did she have to use any aids for a long period of time in order to stop smoking?
A. Not -- not that I really know of.
Q. All right. And Joe, himself, quit smoking right before his operation in February of 1989, didn't he, Mr. Nunnally?
A. I -- I don't know that.
Q. You don't know that. All right, sir. After he got back from Houston, Texas, after this operation, from that time up to his death later in the year, you visited him, saw him and was around him, were you not, when he came back home?
A. Yes, but not very often.
Q. Did you ever see him smoke during that period of time?
A. Not that I recall.
Q. All right. When you were in the family,

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and living at home and Joe was there, were you familiar with the terms "cancer sticks" and "coffin nails" referring to cigarettes?
A. I had heard those terms.
Q. Did you know what -- what that meant? What the --
A. Well, from hanging around people at school and just whatever. Yes, I -- I knew what that was.
Q. Were those terms commonly used in school?
A. I think they were used everywhere. They were used in the media, at school.
Q. Was Joe exposed to those terms?
A. I would think so.

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MR. MERKEL: Objection, Your Honor, calls for speculation on the part of that witness.
MR. LISTON: If he knows.
JUDGE CARLSON: Yes, sir, it can be rephrased.
MR. LISTON: Okay.
Q. (By Mr. Liston) Did you ever hear Joe use those terms?
A. Not that I recall.
Q. Did Joe ever tell you that he tried to quit smoking cigarettes before February of 1989, but

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he just couldn't?
A. We more than likely had conversations about that, but I don't recall him saying that he just absolutely could not quit.
Q. Well, back in your -- when you gave your deposition, if you'd like to look at it, I'd show you -- at page 20, Mr. Merkel -- and you told us that Joe, as I read it, never told you that he tried to the quit earlier but couldn't. Does that refresh your recollection? And I can give it to you if you want.
MR. MERKEL: Your Honor, I'd ask the witness review his deposition, if he's going to be asked about it instead of counsel paraphrasing something.
MR. LISTON: I'll be glad to.
JUDGE CARLSON: All right, sir.
Q. (By Mr. Liston) I think it's on page 20, Mr. Nunnally.
A. What line?
Q. Give me just a second, and I'll try to get there. On line 4, the question was: "Did he ever say, 'Guyton, you know, I can't quit, I can't give them up, ' do you ever remember him saying anything like that?" And what was your answer?

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A. "I don't recall."
Q. What was the -- I don't recall, and what else is your answer there?
A. "No."
Q. Okay. Thank you. Did Joe ever say anything to you about after he was diagnosed with cancer about filing a lawsuit against the tobacco companies?
A. No.
MR. LISTON: Just one second.
Q. (By Mr. Liston) Mr. Nunnally, do you still have -- turn back to page 20 there and let me ask you this question. On line 17, I want to ask you the same question today that we asked you then, and that question was: "Was Joe Nunnally, was he aware of the health risks that had been associated with smoking?" And would you read your answer, please?
MR. MERKEL: And again, Your Honor, I object except to the extent he may know. He can ask him a question of something he knows, but not what he assumes. And I don't think you can read another person's mind as to what they're aware of.
JUDGE CARLSON: He can respond to his knowledge when you cross examine him.

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Q. (By Mr. Liston) What did you tell us then?
A. Do you want me to read it from here?
Q. Yes, sir.
A. "I would think that he would have been aware as most of us are. I don't see where he would be isolated to that information."
MR. LISTON: All right. Thank you, sir. Thank you.
JUDGE CARLSON: Cross examination, Mr. Merkel.
CROSS EXAMINATION BY MR. MERKEL:
Q. Mr. Nunnally, while you still have that deposition open, let's go ahead and finish the answer that you gave. I guess this one is to -- I'm not sure which one of the lawyers deposed you. It wasn't Mr. Liston, I know. Mr. Ulmer, the gentleman seated here, is he the one that took your deposition, this one right here? Don't remember?
A. I don't recall.
Q. Let's go on down through the rest of page 20 and on through page 21 reading your questions and answers, Mr. Guyton. Let's start with the one you already read, question: "Was Joe Nunnally, was he aware, was he aware of the health risks associated
2037
with smoking?" If you'll just read your answer?
A. "I would like to think he would have been aware as most of us are. I don't see where he would have been isolated to that information."
Q. "And the health risks that have been associated with smoking, among other things, are lung cancer, do we agree with that?"
A. "Certainly appears to me" --
Q. "And this information" --
MR. LISTON: I think you cut him off.
A. "As admitted I think by the tobacco companies as recently" --
JUDGE CARLSON: Mr. Liston.
MR. LISTON: Excuse me, Mr. Nunnally. I believe Mr. Merkel cut off his answer on line 25.
MR. MERKEL: We're not even to line 25 yet. I'm on line 23 where I just read the question. He's trying to the read the answer now.
MR. LISTON: Well, I thought he did read it. May I ask that he read it?
JUDGE CARLSON: Let's back up, and you can ask the question again, Mr. Merkel.
Q. (By Mr. Merkel) Let's start all over. Let's start on line 22, read slowly. "And the health risks that have been associate with smoking
2038
and, among other things, are lung cancer, do we agree on that?" Your answer?
A. "Certainly appears to be, yes."
Q. "And this information" --
A. "As admitted I think by the tobacco companies as recently --"
Q. And you were interrupted. "This information of this awareness that you said that Joe Nunnally would certainly have like the rest of us, does that awareness go back to the late '60s or

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early '70s with the Surgeon General's reports, and the information that was regularly appearing in the news media at that time?" And if you'd give your answer, please?

A. "Well, I would think that, you know, when the truth really started coming out and people started delving into like the Surgeon General and people wanted to start publicizing that this was harmful to people's health. When they finally contacted the huge, positive marketing campaign that goes with the tobacco companies and the advertising agency, I sort of forgot what your point was. But I think that's when all started seeing. And when they put the label on the cigarette packs and things like that, of course, I think awareness increased at

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times as to what was going on."

Q. Now, Mr. Nunnally, if we assume, for sake of the record right now, that Joe Nunnally started smoking at eight years of age, which would have been 1960, I guess, and continued on smoking from that point, what was the awareness that you were telling Mr. Ulmer about that you had during this period of time?

Say from 1960 forward, what were your thoughts based on what you were delving from the news, and the media and wherever the information was coming from, you've said that you were aware of some risks. If you'd just try to tell us what your understanding was at '60 and moving on, as it enlarged or grew or whatever the case.

A. Through the media, I was still fairly young at that time. I don't think a that I was reading news magazines and newspapers. But probably just hearing it on a radio or whatever, that smoking could be harmful to you if you did that.

Q. And you said something in here about the "huge positive marketing campaign that goes on with tobacco companies and advertising agents." As well as hearing that it could be hazardous to your health, what else were you hearing during this era?

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A. It was a cool thing to do.

Q. Did you ever hear a tobacco company admit that it was dangerous or hazardous?

MR. LISTON: May want to the Court, we object --

A. Not that I recall.

MR. LISTON: -- prior ruling of the Court.

MR. MERKEL: Your Honor, again, he's the one that raised what this gentleman knew, or heard or thought.

JUDGE CARLSON: I'll overrule the objection.

Q. (By Mr. Merkel) Did you ever read anything where a tobacco company acknowledged yes, it is going to cause cancer, yes, it is hazardous, you shouldn't do it.

A. I haven't heard that really up until today -- even today.

Q. This was an open question as far as you were concerned from 1960 to 1966, Mr. Guyton?

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A. Whether it was bad for you?
Q. Yes.
A. Yes, it was an open question.
Q. Tell us a little bit, Mr. Guyton, about

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your brother. They've asked you some things about his being strong willed and all this, that and the other. Tell us what kind of person he was as far as the way he looked at his job, and his responsibilities to his family and children and so forth.
A. Well, he was -- he was a lovable -- lovable fellow as I -- as I think a lot of people have contested to. He was hard working. He progressed through the ranks of some very difficult companies to be leaders in that company. Loved his family, but he also liked to enjoy life.
Q. Was he a fun person to be around?
A. He was a great person to be around.
Q. Did his family enjoy his company to the best you could observe?
A. To the best I could observe, yes.
Q. And your birthday was when in '48?
A. March 27th.
Q. So Joe is June of '52?
A. June 11th, '52, right.
Q. So four and a quarter, four-and-a-half years difference or something in your ages. When you're young, does four-and-a-half years make a lot of difference in how much you run around with

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somebody?
A. Well, it did in our case. Sometimes it doesn't, but in our case, it did.
Q. As far as following Joe around or knowing Joe's day-to-day activities, how familiar were you with those when you were in high school?
A. I didn't pay attention to Joe at all in high school.
Q. You were an athlete, played sports and --
A. And other things, yes. I mean, he was a little brother. I just didn't keep up with him.
Q. Do you have any idea at all when he first began smoking?
A. I have no idea other than what I've already testified to.
Q. That's the first time you remember seeing him smoke in front of you?
A. Right, uh-huh.
Q. And you didn't smoke in front of your parents, either?
A. No, huh-huh.
Q. So you wouldn't --
A. Not at a younger age.
Q. That's what I mean.
A. Right.

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Q. In other words, if Joe was smoking from 8 to 12, you wouldn't have expected him to do that in front of them, either.
A. No.
Q. And you were -- when you went off to school in 19, what, '66, is that when you graduated

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from Horn Lake?
A. That's correct, uh-huh.
Q. So Joe would have been, at that time, 14-years-old?
A. Probably.
Q. And how long was it in the interval before you came back to have any association with him?
A. Well, from '60 -- from '66, it was probably when I came back in '71 from the service, I got to know him a little bit then. But really I didn't get to know him until around 1980.
Q. So if you left school in June or so of '66, Joe would have been, again, 14 -- just turned 14. Would you have seen him smoking before that interval the first time?
A. I don't -- I don't believe so, no.
Q. Or was it five years later when you came back that you first noticed he was?

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A. When I came back, I guess.
Q. Been a long time, hadn't it, Mr. Guyton. Thank you, sir.
MR. LISTON: Just a few questions, Your Honor.
REDIRECT EXAMINATION BY MR. LISTON:
Q. Mr. Nunnally, as I understand what you just told Mr. Merkel, it would have really been when you came back from the Navy that you first saw him smoke a cigarette; is that correct?
A. That's right.
Q. And that was 1970?
A. Probably '71.
Q. '71. And Joe was born in '52, so that would mean that he would be 19-years-old; is that correct?
A. I think you could say so.
Q. When you first saw him smoke a cigarette?
A. As I recall.
Q. You played football and other sports at Horn Lake?
A. That's right.
Q. And did you smoke while you were in high school?
A. I might have dabbled around with it.

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Q. I believe you were a serious athlete and you told us I believe, that your coaches and the people in athletics there would discourage you people from smoking; is that correct?
A. As all coaches do, I believe.
Q. Right, sir. Now, you were 12-years-old when Joe was eight if I got my birthdays correct; is that right?
A. I would say it's pretty close.
Q. And you were living in the home with Joe at that time?
A. Uh-huh.
Q. And you continued to live with him for the next six years until you got 18 and he would have been 14, and you left; is that --
A. Right.
Q. -- is that correct?

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A. Uh-huh.
Q. And at no time during that six years did you ever see him smoke a cigarette; is that correct?
A. I don't recall.
Q. Okay, sir.
A. -- that.
Q. Did you ever smell tobacco on him during that period of time?

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A. I never smelled Kool Aid on him, either.
Q. Well --
A. No.
Q. Is your answer "no," Mr. Nunnally?
A. No.
Q. He never told you he was smoking, did he --
A. No.
Q. -- during that period of time?
MR. LISTON: I have nothing further. Oh, wait just a second. Thank you.
JUDGE CARLSON: All right. Thank you, Mr. Nunnally. All right. Ladies and gentlemen, let me find out, any of you need a break before the next witness? I'm not hearing anything. Okay. All right. Mr. Liston.
MR. LISTON: May it please the Court, at this time, we would like to have marked the deposition of Miss Jenny Lee Hyde and read certain portions of it to the jury.
MR. MERKEL: Your Honor, we object to the deposition being read. Ms. Hyde is available, as far as I know.
MR. LISTON: Well, she isn't available, and Mr. Merkel should know that she's not available.

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MR. MERKEL: Well, I don't, Your Honor, and I don't know of any basis for the deposition being read. She's a local person according to the deposition.
JUDGE CARLSON: If there's something that needs to be taken up?
MR. LISTON: Yes, sir.
JUDGE CARLSON: I might as well take a break and let you go to the restroom, and we'll get you back after we get through.
(Jury exits courtroom.)
MR. MERKEL: Your Honor -- let me just explain why I don't know what is on here, Bill.
MR. MERKEL: I've got a fax that Mr. Liston hands me that's dated July the 5th, Your Honor, and we've been up here since the evening of July the 4th. I didn't get the fax, don't know anything about what's in here. So that's why the dispute about what I know about Ms. Hyde. I don't know anything about it. And with that -- I mean, I'll let Mr. Liston explain, and I didn't get the fax and don't know what's in it.
JUDGE CARLSON: All right.
MR. LISTON: Well, I don't think we need to go into that argument. Mr. Bell said that he

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delivered it to one of you by hand on Wednesday. Let me just go over the chronology. Mrs. Hyde

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was -- deposition was taken on October the 5th, 1999. Mr. Dodson was there present representing the Plaintiff. And she answered questions under oath in that deposition. Mr. Dodson chose not to ask her any questions.

We had a subpoena served on Mrs. Hyde, and I believe it was served maybe over the holiday this week or early on Wednesday. After she was served, Mrs. Hyde's husband called Mr. Bell and told him that Mrs. Hyde had colon cancer. And that she, on Wednesday, had just had a chemotherapy treatment. We contacted, through Mr. Bell, her doctor, Your Honor. And he has given a letter that we'd like to mark as exhibit to this motion.

MR. MERKEL: I don't think so, Bill. I haven't had anything -- I don't know. You'll have to ask Jack. There are only two of us, but I've never seen it.

MR. LISTON: And the letter, Judge, as you can see, is from her doctor that says she is not physically capable of traveling to and testifying in court. And I don't know what happened to this letter after it was delivered, but it was delivered,

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and I guess we better mark a copy of that letter. Because --

(Exhibit 765 marked for identification.)

MR. LISTON: Your Honor, this deposition is offered under Rule 32A3 of the Mississippi Rules of Civil Procedure having to do with the use of depositions. And that section says that they may be used under certain conditions, one of which is that the witness is unable to attend because of illness or infirmities. It's not hearsay, Your Honor, under Rule of Evidence 804B1 under the former testimony of a witness not available.

And that provides the testimony given as a witness at another hearing of the same -- I'm going to leave out a little -- proceeding taken in connection -- in complains compliance with law in the course of the same proceeding, is it admissible if, and not hearsay, if the witness is unavailable and the opposing party had an opportunity to develop the testimony by direct cross or redirect examination. The deposition shows Mr. Dodson's presence at that deposition.

We submit that we should be allowed to produce Mrs. Hyde's testimony to the jury.

MR. MERKEL: Your Honor, the only

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question about is her availability. Obviously at the deposition in this case, Mr. Dodson was there. We chose not to cross examine any of these people. I don't know a thing about her -- her condition. We've not talked to her, not contacted her. She's not contacted us.

So whatever the doctor's letter says, whether it's possible for her to be here or not, you're going to have to judge that. But if it's going to be read, there's a portion of it, under the circumstances, that we would ask that shouldn't be admitted, because again, it's some of this innuendo stuff that begins on page 14 with line 9. She's

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asked a question, "Well, did you ever have Joe Nunnally in one of your -- in your office with other students when you talked about not smoking?"

JUDGE CARLSON: Excuse me, Mr. Merkel. I don't see that designated in this letter. Line 9 says page 9, line 29 through page 14, line 3, and then it picks up on page 17. I don't see --

MR. MERKEL: Let me get a designation, Your Honor.

JUDGE CARLSON: Okay. Let me just go ahead and state -- I need that letter back here. Looking at the letter -- the letter that will be

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marked in a moment for purposes of the record is Dr. Weir, W-E-I-R, dated July 5th, 2000, states "Ms. Jenny Hyde is currently under my care for the treatment of colon cancer. She completed a round of chemotherapy Wednesday. She is not capable of traveling to or testifying in Court. I request that she be excused from her Court appearance."

So from the Doctor, the doctor's professional opinion is this witness is unable to be in Court. I think clearly it falls under rule 804B1 as to exception to the hearsay rule. And that also that it meet the definition of availability -- unavailability of the witness asset out under 804A4 that the witness is unable to be present or to testify at the hearing because of death or then existing physical or mental illness or infirmity. So proffered testimony clearly meets 804A4 and 804B1.

Likewise, -- that's in the rules of evidence, of course, and then in Rule 32A3, the Mississippi Rules of Civil Procedure, so the Court will permit the portion to be read subject to having to deal with any objections to the proffered testimony as designated. Let's go ahead and take a short break, and when we come back out, I'll see if

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there are any specific objections, and go forward.

(A short break was taken.)

JUDGE CARLSON: Anything to deal with at this point?

MR. LISTON: We're marking it. We'll be through in just a second.

MR. MERKEL: We're putting the designations together, Your Honor. They're going to read them all at once so there won't be any up and down.

MR. LISTON: We're ready, Your Honor.

(Jury enters courtroom.)

JUDGE CARLSON: All right. Ladies and gentlemen, we'll go forward at this time. The Defendant may call its next witness.

MR. LISTON: May it please the Court, we'd like to call by deposition Mrs. Jenny Lee Hyde since she's unavailable because of illness.

JUDGE CARLSON: All right, sir. Again, ladies and gentlemen, based on deposition testimony, you've heard plenty about that, and the witness is unavailable. And so the testimony that she gave on a prior date by way of deposition will be read to you.

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MR. LISTON: Mrs. Hyde was sworn, and then the following questions and answers were given.

(Deposition of Jenny Lee Hyde read into the record.)

MR. LISTON: That's all we have, Your Honor, and we would like to mark a copy of this the deposition for identification.

JUDGE CARLSON: Be marked for ID purposes.

(Exhibit 766 marked for identification only.)

MR. LISTON: Your Honor, at this time we would like to offer the deposition or selected parts of Judy Henry who is with the Methodist Hospital, Methodist Hospital, Houston, Texas, and read those portions that we've designated to the jury.

Mrs. Judy Henry was sworn by the court reporter, and the following questions and answers were given.

(Deposition of Judy Henry read into the record.)

MR. LISTON: That's all we have, Your Honor. We'd like to mark this deposition for identification.

JUDGE CARLSON: All right. Be marked for ID purposes.

(Exhibit 767 marked for identification only.)

MR. BELL: Your Honor, the Defendant next calms Dr. Leslie Alpert by deposition.

(Deposition of Dr. Leslie Alpert read into the record.)

MR. BELL: Your Honor, at this time, we'd move to introduce Exhibits 2 and 3 to this deposition, which are the medical records that Dr. Alpert signed from Methodist Hospital, Houston, Texas.

MR. MERKEL: No objection.

JUDGE CARLSON: All right. Be marked and received into evidence.

MR. MERKEL: Your Honor, for the record, I believe those are already included in P-1 as well, so they'll be in the record two different places.

JUDGE CARLSON: All right.

(Continuation of the reading of Dr. Alpert's deposition.)

MR. MERKEL: What page are you on, please? Are you reading the whole deposition?

MR. BELL: Just designated parts.

MR. MERKEL: Your Honor, we haven't -- I think we'd prefer, Your Honor, just to have the entire -- we'll counter designate whatever they're leaving out. Because I thought that's what had been designated. That's what our designation shows, the entire deposition of Dr. Leslie Alpert.

MR. BELL: We made counter designations, Your Honor, to what they offered, and they didn't offer it in their case. So we've made counter designations of her deposition.

JUDGE CARLSON: Am I understanding the

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initial designation of the entire deposition?
MR. BELL: By the Plaintiff, not the Defendant.
MR. MERKEL: No, Your Honor, by the Defendant. "Defendant R. J. Reynolds may read the entire deposition of Dr. Leslie Alpert."
JUDGE CARLSON: That's what it says.
MR. BELL: And Your Honor, we made objections, we made some counter designations to the testimony. So we're not reading all of it, just the portions that -- to save time in interest of economy. If there are other portions that the Plaintiff wants, we'll be glad to the read those now, or they can come behind us.
JUDGE CARLSON: As I understand what Mr. Merkel that he would counter designate whatever

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--
MR. MERKEL: Whatever they left out, we'd like the entire thing read for completeness. It will save time to do it now rather than us trying to coming back through and splice it later.
MR. BELL: The entire deposition?
MR. MERKEL: The entire deposition.
MR. BELL: We're back to page 24?
MR. MERKEL: I assume, Your Honor, we've skipped a whole lot already. I've been trying to follow and couldn't keep up with where he was, and now I understand why.
JUDGE CARLSON: Start back at the very beginning. Mr. Ulmer, start reading -- where did you start?
MR. ULMER: Your Honor, we started on page 6, but we have not read everything from 6 to where we were on 24.
JUDGE CARLSON: You just need to start back at the beginning maybe excluding any preliminaries, but as far as the testimony, let's just start at the beginning.
MR. BELL: I believe, substantively, Your Honor, it starts on page 10 where we asked her what she did to the prepare for the deposition. Is that

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acceptable?
MR. MERKEL: Well, I believe it begins on page -- preliminaries are on page 5, and looks like the first question begins on page 6.
MR. BELL: Your Honor, that's just preliminary background. If they want it read, we'll read it.
MR. MERKEL: We would like it all read, Mr. Bell, yes, sir.
JUDGE CARLSON: All right.
MR. BELL: Page 6?
MR. MERKEL: Yes, sir.
(Deposition of Dr. Leslie Alpert read into the record.)
MR. MERKEL: Your Honor, we just left out again about seven lines of it.
MR. BELL: We've already read that.
JUDGE CARLSON: Let's just start back. Let's get it going so we can go ahead and move on.
MR. ULMER: Tell me where to start. I'm

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the witness, and you're the lawyer.
MR. BELL: We'll start at page 5.
(Continuation of the deposition of Dr. Leslie Alpert read into the record.)
(Exhibit 768 marked for identification and entered into evidence.)
(Exhibit 769 marked for identification and entered into evidence.)
JUDGE CARLSON: Excuse me. That might be a good place to stop right there and let the jury take a break. Ladies and gentlemen, we'll take a short break and get you back in the box.
(A short break was taken.)
MR. BELL: Your Honor, here's another copy of the deposition. This is where we are.
JUDGE CARLSON: I was trying to look over Mike's shoulder to see. All right. Mr. Bell.
MR. BELL: Thank you, Your Honor.
(Continuation of the reading of the deposition of Dr. Alpert.)
MR. BELL: Your Honor, we have the deposition which can be marked.
JUDGE CARLSON: All right. It will be marked for identification, marked for ID purposes.
(Exhibit 770 marked for identification.)
JUDGE CARLSON: Ladies and gentlemen, let's go ahead and take a lunch break, and see you back at 1:00 o'clock.
(A lunch break was taken.)
(Jury enters courtroom.)

JUDGE CARLSON: All right. Ladies and gentlemen, we are ready to go forward. Once again, you've had the lunch break, and I need to ask of you, if you've had occasion to talk to anyone, anybody made an effort to talk to you or any outside information you may have gained about the case, anything you need to bring to my attention? Okay. I take it, then, there have been no contacts or discussion. Mr. Ulmer.
MR. ULMER: We call Dr. Eric Lang.
ERIC LAND, M.D.,
having been first duly sworn, was examined and testified as follows:
DIRECT EXAMINATION BY MR. ULMER:
Q. Good afternoon, Dr. Lang.
A. Good afternoon, ladies and gentlemen.
Q. What is your name, please, sir?
A. Eric K. Lang.
Q. And are you a medical doctor?
A. I am.
Q. And what is your area of specialty, please, Dr. Lang?
A. Radiology.
Q. And at this time, where and how are you employed?

A. I'm at LS -- at Tulane Medical Center, New Orleans.
Q. At Tulane Medical Center in New Orleans?
A. Right.
Q. How long have you been there?

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A. I have been full-time at Tulane for the past two years. I have actually been on staff at Tulane since 1976.
Q. Okay. Now, I know you're at Tulane. Are you also at any other universities or hospitals?
A. Yes, I have professorial appointments at SUNY, downstate New York, and at University of South Alabama, Mobile.
Q. Are you a professor of radiology at Tulane?
A. Yes, I am.
Q. And I detect the very slightest of accents, Dr. Lang. Where were you born, please, sir?
A. I was born in Vienna, Austria.
Q. Look over here and just tell the jury what circumstances brought you to this country, how old you were and why you came to this country.
A. I was 19, 1950, and I came over as a fellow, on a fellowship program that was fully

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funded for one year to work at Columbia University, a so-called Fulbright Fellowship.
Q. Tell the jury what Fulbright Fellowship is.
A. Well, Fulbright Fellowship was originally founded by the late Senator Fulbright from Arkansas. And it was designated to bring scholars, approximately 20 to 30 a year, into various learned institutions in the United States for a one to the three year tenure.
Q. The 20, 30, was that worldwide?
A. That was worldwide, yeah.
Q. Besides teaching radiology, are you actively involved in patient care there at Tulane University Hospital?
A. Yes, I am.
Q. Just, for instance, and without divulging any patient privileges, how did you spend yesterday?
A. Well, basically, with interventional procedures. Which are invasive procedures, vascular system, catherization of vascular system, biopsies, drainage of abbesses. Yesterday, I happened to have about three vascular procedures, and about four biopsy and drainage procedures.
Q. All right. What is radiology?

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A. Radiology is really a composite for three subareas, diagnostic radiology, therapeutic radiology, dealing primarily with cancer therapy. And nuclear medicine, which basically uses radioactive materials either for diagnosis or for therapy.
Q. Okay. What is your principal subspecialty?
A. My basic subspecialty is interventional vascular radiology and genitourinary radiology.
Q. Would you describe some of the tests that are most commonly done by a radiologist such as yourself?
A. In my particular instance, I would be mostly involved with oncological material. This is some sort of cancerous tumors and diagnoses, and in

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treatment also with vascular entities such as stenosis or vessels that we dilate with balloons or put stints in. Drainage of abscesses, particularly, of course, confirmation of diagnoses by biopsies of various areas where we suspect tumors or infectious disease or whatever.

Q. Some like me are not that schooled in medicine, and we hear about radiologists. But tell the jury whether or not the radiologist is the

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person with special skills in interpreting such things as x-rays.

A. Well, basically the function of a radiologist is to serve as a consultant to the other physicians in our area of special expertise. And, A, to establish a diagnosis, help them establish a diagnosis, and guide them in the proper use of the diagnostic procedures to achieve a diagnose as rapidly as possible.

And B, obviously intervention and treatment. Where we can directly treat a condition by means of image-guided, that means we observe the particular disease, the particular lesion on a x-ray, and then we guide the intervention on basis of this observation.

Q. Let me ask you, though, more pointedly, do you read and interpret x-rays on a daily basis?

A. Yes, I do.

Q. All right. Do you read, and interpret and consult with other physicians on such things as CT scans on a daily basis?

A. Yes, I do.

Q. And have spent how many years doing that?

A. Well, CT scans since they came into being, which is about 30 years.

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Q. And x-rays, how long?

A. X-rays for my entire career, which is about 44 years.

Q. All right. Do you use such tools as MRIs to help diagnose disease?

A. Likewise, MRIs. These, of course, have only been in existence for practical purposes for the past 15 years.

Q. All right. Do other doctors look at and interpret CTs and x-rays, for instance?

A. Yes, they certainly look at them.

Q. Who has -- who has the special training as between other physicians and a radiologist to interpret what's shown on the film?

A. This is pretty well exclusively the main of radiologists. And we serve as the principal consultant to other physicians to help them maximally utilize the information that we generate.

Q. Your primary concentration, I think you've explained to the jury, is in interventional and diagnostic radiology. What's involved in interventional radiology? What is that?

A. Well, interventional radiology is the subspecialty of radiology that is charged with either treating a condition or helping to define a

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condition. For example, if you find a lump

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somewhere, we can, for example, treat this lump by invasive radiology.

We have needles that can be converted into a high energy, basically cooking a tissue. For example, a small cancerous lesion, we can cook by this means. And to be certain that we're in the right area, we use radiologic modalities to steer us to it. So this is intervention radiology.

The other thing, obviously, that is done is if you have an unnormal lesion, this could be an abscess, or it could be an inflammatory lesion. We guide a needle diagnostically into it. We aspirate a sample, we culture the bugs. And then establish on the basis of this information what the optimal type of antibiotic would be to attack the process. Or if it is a solid lesion that could be a cancer, then we guide a needle into it to get an appropriate sample for it, and establish what type of cancer it is and, again, how best it could be treated.

Q. Okay. We -- the jury has heard in this case that in November of 1988 that Joe Nunnally went to the Methodist Hospital in Memphis with a mass in his -- at least one mass in the right upper lobe, and that there was a fine needle aspirant done. Is

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that or not the kind of procedure that you routinely do?

A. Yes, this is a classical procedure that we use.

Q. And the material that is removed on the fine needle biopsy, what is that called?

A. It is cytopathologic and cytologic material, the aspirant, and it is processed cytopathologically.

Q. Would a lay person call that a biopsy?

A. Biopsy if you want to, yeah.

Q. Dr. Lang, I've got your resume here, and it's 84 pages long. I obviously don't want to go through your entire resume. But let's briefly let the jury know what call qualifies you to be here to give expert opinion in the field of radiology. Tell us about your educational background and training, please, sir.

A. I started medical school at University of Vienna, Austria. I then went to Columbia University, New York. I finished my medical degree in 1953. I then took a research residency in radiology at University of Vienna for one year.

I did my rotating internship at the University of Iowa in Iowa city for one year,

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followed that with residency in internal medicine at University of Iowa for one year then came to Johns Hopkins Hospital for my residency in radiology for three years.

After that, I stayed on staff at Hopkins for some time.

Q. Is that John Hopkins in Baltimore, Maryland?

A. Yeah.

Q. Are you board certified in the field of radiology?

A. Yes, I am.

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Q. When did you become board certified in that field?
A. I'm sorry, sir.
Q. When did you become board certified?
A. In radiology in 1959, nuclear medicine 1973, and then we have a 10-year limited certification that came into existence now, which I have in vascular interventional radiology, 1996 to 2006.
Q. Are you an American citizen?
A. Yes, I am.
Q. When did you become an American citizen?
A. 1960.

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Q. Did you serve in the American military?
A. Yes, I did.
Q. When did you serve in the American military?
A. 1961 to '64.
Q. Now, we've established that you're at Tulane now. How did a fellow make it from Vienna to John Hopkins in Baltimore down into Louisiana? Tell the jury about that.
A. I had worked scientifically with a cardiologist by the name of Dr. Edgar Hall, who was appointed Dean for the medical school in Shreveport. And he asked me to come down and head the department as professor and chairman, director in Shreveport, which is the second medical school at LSU. We have one in New Orleans, and we have one in Shreveport.
So I served in Shreveport as director and chairman for eight years. In 1976, myself and three of my staff members were recruited to go down to New Orleans because there were problems there in staffing the department in New Orleans. So after that, I served in New Orleans at the medical school as professor and chairman.
Q. Now, when you say professor and chairman, I know you teach as professor. But do you also take

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care of patients, and did you also take care of patients during that time period?
A. Yes, I took care of patients, and I was also director of the department, administrative director.
Q. How many years, total, did you spend in the LSU system?
A. Total with my sabbatical years, 28 as chairman, 24-and-a-half.
Q. Up here in this part of the world, there are a lot of different football fans, but I can tell you none of them are LSU fans, I don't think, although there may be an exception.
JUDGE CARLSON: I think you've got one.
MR. ULMER: We've got one.
Q. (By Mr. Ulmer) Are you a LSU fan?
A. I guess so. I -- are you referring to --
Q. To the LSU Tigers? Are you a Tiger fan?
A. That's a different story. I'm a great tiger fan. That's the tiger, personal friend of mine?
Q. How is the tiger a personal friend of yours?

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A. One of my patients.
Q. So -- tell the jury?

A. About 10, 12 years ago --
Q. How owe you --
A. LSU has a pet tiger which was allowed on the football field until I guess about 12, 15 years ago when the local con stab Larry banned him from further appearances in the open, but he was really a very nice cat, except he got sick one time, and they couldn't figure out what he had. So I finally got recruited as a great expert to look at him.
I had never seen a tiger x-ray before in my life, neither had the veterinary of ear infection. But it turned out that the tiger had an ear infection, which we did diagnose with x-rays, and we treated it. And the tiger recovered, and you know, his name was Mike the tiger. And I got a Christmas card, Mike the tiger, and below it says, I love you, Michelle. Because the original Mike had died some time ago, and the replacement Mike was really a female, but she was a very cute cat.
Q. So you're an expert on, what is that, ear infections in tigers, you're not claiming --
A. Expert, I have seen one, treated one and won one, so that's okay.
Q. Okay. All right. With that out of the way now, we can get back, I guess, to more serious

business. You've taught, I know, for a long time. Do you teach not only medical students, but doctors as well, Dr. Lang?
A. Yes, we do.
Q. Approximately how many students have come under your direct supervision and have been taught by you over the years in the field of radiology?
A. Medical students somewhere between three and 5,000. Now, physicians, that means residents in training for the specialty of radiology, somewhere in the neighborhood of 140.
Q. Okay. This may be obvious, but have you taught courses in the radiological diagnosis of -- of cancer and the treatment of cancer?
A. Yes, I have.
Q. For all areas of the body?
A. Predominantly for the genitourinary tract, but also for all oncological involvements, that is cancerous type of indications.
Q. You've already told the jury that yesterday you spent your day in a hospital setting doing diagnostic and therapeutic radiological procedures on patients. Are you actively involved at this time in the practice of radiological medicine?

A. Yes, I am.
Q. On a full-time basis?
A. Yes.
Q. Approximately -- tell me the approximate number of abnormal abdominal and chest x-rays and CTs that you would see on an average month?
A. About 4 to 500.
Q. All right, sir. Now, we've talked about

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the fact that, as a radiologist, you're often asked to consult with other physicians such as an internal medicine doctor or a pulmonologist. Would those be examples?

A. Yes.

Q. And when they come to you as a radiologist, you know, what are they asking you when they -- what do you see in this film and what does it mean, those kind of questions?

A. Yes. They were first asked for an opinion on the disease entity that we're looking at. And for guidance and further investigating it. What other examinations we would suggest, and how we could further the diagnosis.

Q. Okay. And I think we've already established that -- or let's establish, do you routinely do biopsies of cancer and other materials

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that need to be removed from the body?

A. Yes, I do.

Q. And you routinely do such things as this fine needle aspirant procedure that you talked about?

A. Yes, I do.

Q. And do you or not do that with the help of a CT scan?

A. Mostly, about 95 percent will be done with a CT guidance, some of them may be done under MRI guidance, magnetic resonance, some of them may be done with ultrasound guidance. In the old days, a lot of them were done with fluoroscopic guidance.

Q. Is the purpose of the CT guide to make sure the needle is exactly in the tumor as opposed to being somewhere else?

A. That's exactly the purpose. You confirm the source where you get the biopsy from. This is important. If you get a negative biopsy, you wouldn't have documentation where you get the material from, it would be meaningless.

If you get a negative biopsy and you know you were in the middle of the lesion, you know this is not a neoplasm.

Q. One of the things that I think we've done

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a poor job of is that we use the word tumor, and lesion and other such words kind of interchangeably. Should they be used interchangeably or not, Dr. Lang?

A. We use the term "lesion" for anything that we have not defined further. We then proceed to classify it after we know whether it's an infectious lesion or whether it is a neoplastic lesion or cancer. But lesion is the comprehensive overall term.

MR. MERKEL: Excuse me, Your Honor, I don't know if we're still qualifying the witness, whether he's been tendered or whether we're into some opinion testimony. So --

MR. ULMER: I'm still qualifying, Your Honor. I'll tender him in a minute.

MR. MERKEL: All right. That seemed more like opinion testimony than qualification.

Q. (By Mr. Ulmer) In absence of an autopsy

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or surgery, how do you determine the location of a lesion?
A. By biopsy.
Q. Guided CT biopsy?
A. Guided CT biopsy, yes.
Q. Is there any clinical way to determine

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the location of a lesion within the body more accurately than through radiological procedures that you perform?
A. With exception of endoscopic definition. For example, if you have a lesion in the stomach, you could put a gastroscope down and identify it with such. So if you can reach it with a scope that has an op particular, you can identify the lesion this way. Other than that, if you can't get with an optical type of scope to it, then it would be the most optimum modality.
Q. Does the location and the appearance of the lesion help you determine an appropriate diagnosis?
A. Yes, it does.
Q. Is that important information?
A. It's extremely important.
Q. Now, Dr. Lang, in looking through your resume, I see that you are a member of the American College of Chest Physicians. Are radiologists normally invited to participate in the American College of Chest Physicians?
A. Normally not, but I got into it because I have a special interest and developed pulmonary angiography at that time which is heavily used in

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that field. And, therefore, was invited as a fellow into this organization.
Q. Was that the first such procedure ever performed in this country?
A. No.
Q. Now --
MR. ULMER: Now, I'm going to lead a little bit, Your Honor, to get through the qualifications with the Court's permission.
Q. (By Mr. Ulmer) You have lectured extensively at most major institutions in the United States, have you not?
A. I have.
Q. And you've lectured in foreign countries?
A. I have.
Q. And have you lectured on things such as cancer treatment procedures?
A. Yes, I have.
Q. Many times?
A. Many times.
Q. And are you involved in any research at this time?
A. Yes, we're basically involved in primary research on genitourinary tumors. We're involved in the research efforts on biopsy and safe biopsy

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procedures of this nature.
Q. Do you have anything going with the National Institute of Health?
A. Yes, I do.

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Q. What is that?
A. We have asked for a grant to utilize CT in the detection of abnormalities in the chest of very fine cuts, very thin cuts, one millimeter or less.
Q. In look through your 84-page resume, I see you're a member of 24 different medical societies, and rather than go through them all, let me just give the jury just a sample and tell me if you're a member of that society, the Radiological Society of North America?
A. Yes.
Q. The American College of Radiology?
A. Yes.
Q. The Society of Uroradiology?
A. Yes.
Q. The Society of Nuclear Medicine?
A. Yes.
Q. The American Neurologic Association?
A. Yes.
Q. The American College of Chest Physicians?

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A. Yes.
Q. The Society of Cardiovascular and Interventional Radiology?
A. Yes.
Q. And the American Fertility Society?
A. Yes.
Q. Now, tell this jury how many journal articles, and books and chapters of books that you have written.
A. Approximately 350 journal articles, and approximately 70 books or chapters in books.
Q. Did you write anything for the July issue of "Radiology"?
A. This year?
Q. Yes, sir.
A. Yes.
Q. What was the name of that article?
A. This was a technique, patch technique for facilitating biopsy of lung lesions and avoiding pneumothorax. It's in this weeks publication of "Radiology".
Q. Are any of your articles peer reviewed?
A. Yes, the majority.
Q. And just tell the jury what it means to put your article in a journal that is peer reviewed?

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A. "Peer reviewed" simply means that at least two editors evaluate an article before they determine where it should be published or not. Nonpeer reviewed, you simply submit it and most of these articles may be published. Peer reviewed, you have at least two experts looking at it before they decide whether it is for publication.
Q. Are you a peer reviewer?
A. Yes, I am.
Q. And are you on any editorial boards?
A. Yes, I am.
Q. Now, have you ever testified in Court before?
A. Yes.
Q. How many times?

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A. Twice.
Q. Have you ever testified in a case involving tobacco?
A. One, yes.
Q. One time. And where was that?
A. It --
Q. What state?
A. Louisiana.
Q. All right. Now, what do you charge for interpreting CTs and x-rays in your hospital setting

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everyday?
A. Well, you have a charge system that is developed by our business office which is basically based on a rate of $400 per hour of time commitment.
Q. What are you charging in this case to prepare to give testimony in it?
A. The same.
Q. Now, let's provide the jury with just a little bit of background on x-rays and CTs before we get to -- get to Joe Nunnally and his case. And just tell the jury, briefly, what a x-ray is and how it's done.
MR. MERKEL: Your Honor, are we tendering him yet in?
MR. ULMER: I still haven't tendered him, Your Honor.
MR. MERKEL: Well, then, I object to asking him opinions until he's been qualified by the Court, Your Honor.
JUDGE CARLSON: Let's get through the qualification, and have him tendered for voir dire.
Q. (By Mr. Ulmer) All right, sir. Just briefly, what is a x-ray, how is it done?
A. A x-ray beam is generated. It is sent through the patient, and a photographic plate is

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behind the patient and records what is going through. So basically the through-coming radiation generates the picture.
Q. All right. Is the x-ray the important diagnostic tool in diagnosing lung cancer?
A. Yes, it is.
Q. What about the CT? How does it differ from a x-ray?
A. The CT is the principal examination with high fidelity and high value of diagnosis. It is also a x-ray beam that is sent through the patient. But rather than to put on a photographic plate, it is then received by monitors, and in then the monitors process it digitally to make an image. So it is a digital reproduction of what is going through rather than a direct picture.
Q. Now, are CTs more accurate than x-rays?
A. Yes, they are.
Q. In reaching your opinions in this case, have you looked at all the available x-rays and CTs with respect to Joe Nunnally?
A. I have.
Q. All right, sir. Now, do lung tumors have certain signature characteristics? And by that I'm talking about size, shape, density, direction of

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growth and those kind of things that enable you --
MR. MERKEL: And again, Your Honor, we object until he's qualified. I mean, these are opinions that certainly can be given later but not at this point.
JUDGE CARLSON: Have you gotten to tendering him?
MR. MERKEL: We object to that question that he's asking, Your Honor, because it is an opinion.
JUDGE CARLSON: Let's go ahead -- I mean, I think we're pretty well to the point of having him qualified to the extent of having voir dire and tendered for voir dire.
MR. ULMER: Your Honor, we offer Dr. Lang at this time as an expert in radiology and radiological diagnosis of lung cancer and diseases of the chest.
JUDGE CARLSON: All right. Voir dire?
MR. MERKEL: Just a few questions, Your Honor, very briefly.
VOIR DIRE EXAMINATION BY MR. MERKEL:
Q. Good afternoon, Dr. Lang.
A. Yes, sir.
Q. You told Mr. Ulmer a moment ago that you

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had, I think you said, only been involved in one other tobacco case before; was that right, sir?
A. Testifying, yes, sir.
Q. Testifying. Okay. How many times have you been involved on behalf of a tobacco defendant, either in reviewing a chart, giving a deposition, testifying, whatever the case may be?
A. About five or six times.
Q. All right. And I have some of those depositions, so that's what I'm going to be referring to and try to move through this in a hurry, Dr. Lang, I'm sorry. As I understood what you said, your specialties are in vascular radiology, and genitourinary type radiology?
A. Genitourinary and oncological radiology, which is cancer radiology diagnosis.
Q. Radiation of tumors to try to irradicate them with radiation?
A. Well, I'm trained in that. But basically, it is chemotherapy, for example, where you introduce catheters into the supply vessel of the tumor and provide chemotherapy, chemoabulization, where you put small particles of chemotherapeutic agents into the tumor, sensitization for external radiation therapy with

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chemotherapeutic agents, and also --
JUDGE CARLSON: I think you can move back a little bit from the mic.
A. Or broncotherapy which is the introduction of radioactive material through catheters into the vascular supply of tumors.
Q. (By Mr. Merkel) As far as diagnostic radiology, Dr. Lang, how much of your practice would be devoted to the genito tract or the urinary track area as opposed to the chest?
A. Well, that's hard to answer, because in

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many instances, genitourinary tumors metastasize to the chest. So practically with every genitourinary tumor, we get chest films, and we get chest CTs. Because this is a common way of having metastasizes, and this is a primary thing we have to evaluate.

Q. So there are two different x-rays that are involved?

A. That is correct.

Q. One is a chest x-ray, and one would be a stomach film of the lower?

A. Precisely.

Q. But you check both areas, regardless of where you think the thing --

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A. Absolutely.

Q. -- began?

A. Absolutely.

Q. Now, of your total time, Doctor, you're a teacher now, correct?

A. Yes.

Q. And of your weekly time, monthly, however you want to break it down, annually. What percentage of your time would be devoted to actual patient care, what percentage to teaching, or laboratory type medicine, and what percentage to this type stuff, this medical legal work?

A. Approximately two-thirds of my time is devoted to patient care, often I will be accompanied by physicians in training. Most of the time, they will be with me in direct care, but I will execute the patient care as the primary physician.

Approximately 10 percent to pure teaching. That means sitting in an auditorium and lecturing. And practically all of the remainder of the time to primary research work in the laboratory or otherwise.

As far as your question is concerned, my involvement with testifying, it is infinitesimal. I have looked at about six cases of this nature. I

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have been subpoenaed as -- in Louisiana, we have a system on malpractice cases where a panel of three physicians has to arabit cases. I have seen probably about 10 of these cases where the Court requires our services.

So the sum total time commitment of that is extremely small, less than one percent of my total time.

Q. Okay. And as far as this case is concerned at $400 an hour, Doctor, what time do you have involved in this case up to now?

A. In this case, I would say quite a bit, probably 20 hours, maybe even 25 hours.

Q. And that was before you traveled from New Orleans here?

A. No, that's --

Q. That's up to right now?

A. That's the time, yeah, that I have involved in it.

Q. So by the time you get back to New Orleans, whenever that is, 25 hours or so?

A. I don't know. That depends on how good

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the connection in Atlanta is. I don't -- I don't charge for travel.

Q. If you left right now, you'd be another

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five hours getting home?

A. It would be three-and-a-half hours over to Atlanta, that is right.

Q. That would be the best connection you could have?

A. That is true.

Q. And about $10,000 on this particular case would be a ballpark figure?

A. It may -- may be about like that, yeah, 8,000, 10,000, I don't know exactly, somewhere in that line.

Q. And I believe based on your testimony in some other cases, Dr. Lang, you do not, in the part of your practice where you're making diagnoses, you do not make any attempt to determine what the cause of a tumor was --

A. Oh, yes.

Q. -- in other words, whether it was cigarette smoking or whether it was something else?

A. No.

Q. You make no attempt to correlate those two statistically or otherwise?

A. Yes, we do. For example, we have an investigative series going on on bladder carcinoma where we correlate it very closely to cigarette

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smoking. And we correlate it very closely to aniline dyes.

Q. Let me ask you if you remember, Doctor, testifying in Circuit Court in Duval County, Florida in the case of "John Keggen versus R. J. Reynolds"?

A. Yeah.

Q. You were asked that question at that time, but you made no conclusion of whether it was caused by cigarette smoking, and you said statistically, no, I don't correlate it.

A. That wasn't bladder cancer.

Q. No, I'm talking about lung cancer?

A. No, I'm talking about bladder cancer.

Q. Oh, okay.

A. I said we have a specific protocol where we're correlating the occurrence of cancer, carcinoma, to cigarette smoking --

Q. In the bladder?

A. -- in bladder cancers, and the use of aniline dye in bladder cancers.

Q. But you've never made any such studies or correlations with regard to lung cancer?

A. No, sir.

Q. And you are not an epidemiologist of any sort?

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A. No, sir.

Q. Nor a pathologist?

A. No, sir.

Q. And in the way the system works, you're sort of the first line of discovery. You, by picture, either x-ray, or CT or MRI or whatever, you discover what appears, at least by image, to be a

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lesion of some sort in some part of the anatomy?
A. Yes.
Q. And then you refer that over to a pathologist who, in some form, takes an aspirate or a specimen one way or the other, a biopsy, if you will, or something of that nature. And then they tell us what the actual lesion is, what it is made of?
A. No, that wasn't precisely describe it. Basically what we do is we may discover the lesion. The average patient in the United States today has at least 2.4 x-rays per patient. So this is a very heavily used modality. We discover the lesion. Then we will advise the physician and patient as to our ability to further amplify the diagnosis by additional tests. Very frequently, this would be, for example, MRI or ultrasound tests of the same area to further define the lesion and to come up

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with as close as possible a high probability diagnosis.
Now, lastly, we would then, again, with consensus of the other physicians involved in it, proceed in many instances to a biopsy to provide histopathologic material for a diagnosis, or to provide material for doing a culture and establishing a bug or whatever it is. And establish the type of antibiotic that you need to treat it.
Q. And then the primary physician in whatever specialty he may be takes your reports, the pathology reports, and he, then, determines a course of treatment with more consultation, if he needs it, and he then directs the treatment?
A. Well, again, we will work in concert with the pathologist. For example, there are some tumors, specifically bone tumors, that are literally not diagnoseable pathologically. But they are diagnoseable radiologically, and you have a combined diagnosis.
Likewise, in other areas, we can provide a probability diagnosis in the range of 98 percent, in many instances on basis of the appearance of the lesion and a number of other characteristics. So the final diagnosis is expressed as a concert of

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opinions between the pathologic data, the radiologic data, and, frequently, biochemical data that reveal the presence of a tumor. That may be on blood samples, urine samples, whatever have you.
Q. So to kind of sum that up, the final diagnosis and the plan for treatment is arrived at by the primary physician in charge of the case with whatever help he needs from radiology and pathology, all the way through.
A. Well --
Q. In other words, if it's a difficult thing, than it requires more assistance of yours than the first report, then that guy will get your assistance all the way to the end when he finally reaches a final diagnosis?
A. I would say in our particular area, this is not the way it is. We have a tumor board, for example, at which we have all specialties,

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subspecialties represented. And it has to be a composite opinion. It is never the opinion of one person. In fact, we record the data of the findings of the tumor board, each case has to be presented. There has to be a radiologist, there's usually a radiation oncologist there. There's a chemotherapist there. There's mandatorily a surgery

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surgeon there.

May be the primary referring physician there, pathologist, composite of at least six people who arrive at the treatment recommendation. And then the patient, of course, finally decides whether he accepts the treatment recommendation or not.

Q. So the composite diagnosis and treatment plan, then, has input from everybody involved, including whoever is sitting in your position as the initial radiologist?

A. Yes, sir.

Q. And whatever they come up with in the end includes your counterparts' contribution to whatever extent is needed or supplied?

A. Yes, sir.

MR. MERKEL: Okay. That's all we have on voir dire, Your Honor.

JUDGE CARLSON: The Court will declare Dr. Lang is an expert in the field he's so offered.

CONTINUATION OF DIRECT EXAMINATION BY MR. ULMER:

Q. Dr. Lang, before you were voir dired by Ms. Nunnally's attorney, I was asking about tumors in the lung, if their size and their shape and if their appearance help you make a diagnosis as to what type of cancer that is. Is that so or not?

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A. Yes, that is definitely so.

Q. Do squamous cell tumors, do they have certain radiological characteristics that are distinct or different from sarcomas or lymphomas or other things of that nature?

A. Yes, they do.

Q. When you look at a x-ray or CT scan, can you make a radiological judgment as to whether a tumor is a squamous cell carcinoma or a sarcoma?

A. Yes, we can, with a very high degree of probability and accuracy.

Q. What -- just a little more background before we look at the time Mr. Nunnally's x-rays, just so we're on the same page. What is bronchogenic cancer?

A. Bronchogenic cancer is a cancer that develops from the epithelium surface of the bronchi.

Q. And what is carcinoma?

A. Carcinoma is simply a cancer from anywhere. Carcinoma can be from anywhere.

Q. And we've talked about squamous cell carcinoma?

A. Squamous cell, certainly is one that occurs in the lung. Squamous cell carcinoma also occurs in the skin. The most common squamous cell

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carcinoma would be one of the skin.

Q. Is the squamous cell tumor in the lung associated or not with cigarette smoking?

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A. Yes, it is.
Q. Tell the jury what a sarcoma is.
A. A sarcoma is a interstitial type of tumor that comes from the interstia, the cells in between. Such as, for example, cartilage or binding cells between the superficial cells. And is likewise a malignant tumor, but distinctly different from the carcinomas that are from surface epithelium, from surface areas.
Q. Are sarcomas connected with or associated with cigarette smoking?
A. No.
MR. MERKEL: Your Honor, we object to opinions about what's connected to cigarette smoking. He's not been tendered as an expert in that area. He has no background in it. Says he doesn't even try to correlate cause of the lung cancer to smoking.
JUDGE CARLSON: Based on the over all record, I'll overrule the objection.
Q. (By Mr. Ulmer) Now, were you asked by -- by me and by R. J. Reynolds to review all the

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radiological evidence that was available and provide an opinion regarding Mr. Nunnally's disease process from a radiological point of view only? Were you asked to do that?
A. Well, I was asked by you attorneys. I've never met anybody from R. J. Reynolds company.
Q. Did the attorneys ask you to do that?
A. Yes, the attorneys did asked me to do that.
Q. And have you done that?
A. Yes, I have.
Q. Have you reviewed all the available x-rays on Joe Nunnally?
A. All that were made available to me.
Q. And all the -- all the CTs that were made available to you, you've reviewed those?
A. All that were made available to me.
Q. Have you reviewed Joe Nunnally's medical records?
A. Yes, I have.
Q. Have you reviewed the deposition of Dr. Alpert?
A. Yes, I have.
Q. And Dr. Alpert is the physician in Houston, Texas, that was what kind of specialist,

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Dr. Lang?
A. She's a pathologist.
Q. All right. Now, did you review the deposition of Dr. Routt, the radiologist in Memphis?
A. Yes, I did.
Q. If you were asked in a hospital setting to give a second opinion in your area of expertise, radiology, would you rely simply on the report of the other radiologists, or would you insist on seeing the actual films?
A. No, I would have to see the actual films.
Q. All right. If Dr. Burns testified that he did not look at the actual radiology, the films, and he did not look at the slides --

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MR. MERKEL: Objection, Your Honor, trying to pit one expert's testimony against another. I don't think that's proper. He can ask a question of the witness's opinion but not couched in terms of what somebody else may say.

JUDGE CARLSON: Again, I'll overrule the objection.

Q. (By Mr. Ulmer) Let me back up, Dr. Lang.

A. Yeah.

Q. Okay. If Dr. Burns testified that he did not look at the actual films, and he did not look at

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the actual pathology, the slide material, the tissue material, but he simply relied for his second opinion or his import opinion on the reports of others, would that or not violate the standard of medical care at your hospital?

A. We, basically, as radiologists, are compelled to look at the original films and certainly also at the reports that are generated, but the basis for second opinion should be the original films.

Q. Now, I'm going to ask you a number of opinion questions over the next probably 30 minutes, Dr. Lang, and I want you to build into all of my questions the requirement that any answers you give be based on a reasonable degree of medical certainty. Will you do that for me?

A. Yes.

Q. And have you prepared or had prepared at your direction certain exhibits and illustrations that would be helpful in explaining your testimony to the jury?

A. Yes, I have.

MR. ULMER: I would like, with the Court's permission, for Dr. Lang to be permitted to step down.

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JUDGE CARLSON: Doctor, you can step down.

MR. ULMER: If he could.

THE WITNESS: With your permission, Your Honor.

MR. ULMER: A set of exhibits for the Court.

THE WITNESS: With your permission, Your Honor, these are first introductory drawings that illustrate the use of x-rays on CT if, I may present these first.

JUDGE CARLSON: All right.

A. This is a schematic drawing of the human lung. You can see the trachea, wind pipe coming down here. And then it divides into two main sections. These are the main stem bronchi that now go to the lung. Now, these divide in the lung and supply the air to go to the lung for exchange for oxygen.

Now, we have three distinct lobes on the right side in the right lung. We have two lobes on the left side. Importantly is that there are different zones in the lung. The central zone of the lung is approximately two inches around the area where the bronchi come in, which we call the

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"hilar." And the peripheral zone of the lung is all the rest of it, which is, again, about two-and-a-half inches deep. This is, to some degree, important because the central zone is accessible to a technique that is called "bronchoscopy."

We can stick a tube down and have an optic and can directly look at lesions. Whereas in the periphery, this is not accessible to the direct visualization, so we rely entirely on x-rays or CTs to identify lesions there and/or biopsy lesions.

Q. (By Mr. Ulmer) Let me ask a question, please. Leave that up for just a minute, Dr. Lang. In Joe Nunnally's case, was his -- well, tell the jury about the tumors that were found, where they were located.

A. In Mr. Nunnally's case, there were three tumors identified in the lung. By far the largest tumor was the tumor peripherally in the right upper lobe in the back and to the very periphery of the right upper lobe. Then there was a second, much smaller tumor, which was also in the right upper lobe that was immediately in front of it.

And the third smaller tumor was located in the right middle lobe about an inch and a quarter

2100
size tumor in the right middle lobe also in front, and I will show you that, then, on the obliques a little better the location.

Q. With respect to the large tumor that was in the right upper lobe, what was its approximate size?

A. It was approximately 15 by 8 by 12 centimeters, a centimeter being two-and-a-half centimeters to an inch is about six inch to five inch, a very large tumor.

Q. And you said there was a smaller tumor also in the right upper lobe?

A. Immediately in front of that is a smaller tumor that is just a little less than an inch.

Q. And finally there was a tumor in the middle lobe?

A. In the middle lobe, there is a third tumor that was approximately an inch and a third.

Q. Okay. Is the location of the 15 centimeter mass in the right upper lobe, was it central or peripheral?

A. It was extremely peripheral.

Q. And is that of significance?

A. Yes, it is.

Q. All right, stir. When you see a cancer

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that's related to smoking, where is it most often found?

A. Most likely, it's originating from the central bronchial areas. And it's a central tumor, originates from the epithelium of the central bronchi most often.

Q. In looking at this diagram which is number, I believe, 471, when smoke comes down the wind pipe or air, where does it go? Where does it enter the lung? Smoke or air, when it enters the

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wind pipe, where does it go into the lung?
A. Well, it will go along the bronchi into the lung. It will then develop, go out into the air sacks.
Q. Are you ready for the next board --
A. Yeah.
Q. -- to help illustrate your testimony?
A. Yeah.
Q. Stay right there. I'll get it for you.
A. Okay.
Q. Stay there. I'll help you. Let's put up what's been marked as AWN-000472, and just tell the jury what is being illustrated here.
A. This will help you to understand the location a little bit better. It is slightly

2102

oblique. The patient here is turned slightly like that, okay.
Now, on this you can see against the right upper lobe, and you can see that the tumor in Mr. Nunnally's case was located way to the back and peripherally, in this general area. The second, smaller tumor, was further in front, in this area here. And the third smaller tumor that we were talking about was located in the middle lobe. Again relatively and materially, all of them in the periphery of the lung.
Q. All right, sir. Let's put up number 473, and let's tell the jury what we're looking at in 473, first, is this x-ray that's been superimposed on 473, is that an actual x-ray of Joe Nunnally?
A. This is an actual x-ray of Joe Nunnally that was selected. And this the x-ray relates on the x-ray -- I'm sorry. Relates on the x-ray -- I'm standing in front of you --
Q. Let's move?
A. Relates on the x-ray the location of the upper lobe, and you can see it's all the way to the periphery here, right, the white thing. The white thing is a tumor. Just as a brief explanation, the dense white stripes that you see here are the bones

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of the thoracic cage. They contain calcium and, therefore, don't let the x-rays through so they present as a white stripe.
The black areas is the aerated lung, because that's air, and, therefore, the x-rays pass through it, and it projects black. The heart is relatively dense and absorbs the energy. Therefore, it is relatively white and here is the diagram or the liver below, again, it's dense, so it's dense.
If you have a tumor in the lung and no more air in the lung, therefore, it presents white, because it absorbs it. So you can nicely see here the delineation of the tumor sitting up here, which in relationship to our drawing is in the very periphery of the upper lobe on the right side, sitting in here.
And this is the same projection, so we tried to show you on the patient where it would be, and how it projects on the x-ray.
Q. All right. Let's look at this next exhibit which would be 474 and tell the jury what

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we're seeing again here, and is this from the Methodist Hospital South, Joe Nunnally, November 21, 1988, CT?

A. This is what we call a CT scout film.

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It's again a plain chest radiograph, and you can see these white stripes going across it. Now, these are the indications of how we reconstruct the information that we have. We try to look at it instead of this way, we try to look at it from top on a slab that is that thick. So theoretically what we do is, we cut the patients in little pieces all the way down, and we look at each one of the pieces in a slice-like fashion. That gives us the opportunity to look at a relatively thin section of tissue and see what it looks like.

And we number these so we can correlate them to the tables that we print out. The images that come out of the CAT scan, so-called CT or CAT scan are always in a horizontal plane oriented. Whereas this one, the chest x-ray, of course, is an upright vertical plane oriented.

Q. And again, before you remove it, is the -- what's the thickness of the slices or the cuts that we're making here on this particular film?

A. This one happens to be one centimeter thick slices, approximately one-third to one-half inch in thickness. They're about that thick, the slices (indicating).

Q. Is the setting of the slices on the CT

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important or unimportant?

A. Yes, it's very important, and of course, the most modern techniques take extremely thin slices of less than one millimeter. So we have a very high resolution, but one centimeter slices will suffice for many particular informations that can be derived from it, can be done.

Q. Before we go, over here, if I -- this is the left side here, and this is the right side here.

A. This is the left side, this is the right side.

Q. We see black in here indicating that there is or is not tumor present on the left side?

A. As I say, a lung that contains air, offers no resistance to the x-ray; therefore, it is black. So wherever you have aerated lung, you have black, like here and here. If you have soft tissue, it absorbs the energy. And, therefore, it presents white. The denser the tissue it is, so the whiter it is. So ribs are very dense, so they cast a very dense white stripe. A tumor is relatively dense. It has a relatively white appearance.

Q. Go ahead and tell the jury what we're looking at on 475, and make sure everybody can see.

A. Now, this is an appropriate slide that we

2106

have taken through about this level here.

You can see we have -- I'm bringing the slice level through that here, and I'm documenting to you the various areas, the tumor area, which is in the right upper lobe in the back.

Q. Is that shown in green?

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A. Green. The small purple one is the small tumor that is in front of it.
Q. In the right upper lobe?
A. In the right upper lobe. The area that you see here are on large vessels, the mediastinum, and now we are looking at the thing from the top.
Q. And this is actually on Joe Nunnally, is it not?
A. This is the actual slide derived from the patient. You can see here again the very dense white areas that you see here.
Q. What is that?
A. Are the ribs.
Q. You can see a very dense white area here, extremely dense, that's the vertebral body, cutting through the back of the vertebral body here. Then you see an area that is all black, and that is air rated lung. That's the aerated lung on the left side. Then you see some black here which is aerated

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lung on the right side. And then you see the mass, and you can see the mass goes all the way to the ribs, so it's in the periphery. It's way, way out in the lung. It is very large.
It is homogeneously dense, doesn't have any holes in it, doesn't have any density differences in it. It's homogeneously dense, and there's a little bit of aerated lung in this area here. Which means right in here, which means the mass is not extended completely to the mediastinum. And then here we have the so-called mediastinum structures which happens to be the order at this particular level.
Q. All right. Let's put this one aside, let's look at 476.
A. 476 is just a little bit lower, and we are cutting through more or less the same area here. And you can see here the slice level, and this is then indicated on the reference slice. We can read off where the reference slice is so we know exactly at what level we have cut it.
And on this particular one, you can again see the dense white areas. Those are the ribs. You see the intensely black area here which is aerated left lung. You see intensely black area down here

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which is the remainder of the area of the right lung. And then we have, again, this very large, more or less homogeneously dense mass, which comes all the way from the periphery, all this way from the thoracic cage toward the bones, toward medially and fills this entire space.
A little bit in front of that, you'll see another one, looks like a little donut. A little donut lesion, it's much smaller. It has a dense rim and sort of a black center in it. And once again, you can see that in the middle here toward the mediastinum, you have again aerated lung, and then you have mediastinal structures.
Q. All right, sir. Now, I want to put up a x-ray film for Joe Nunnally that was dated in 7/1/85. It says Joe Nunnally; does it not?
A. This is Mr. Nunnally's film, and it's

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dated July 1, 1985. It's a plain radiograph, and basically relatively unremarkable. You can see that both lungs are more or less homogeneously black. There are a couple of fibrotic scans and calcification, lobulous. Other than that the lungs look pretty good. The heart here, and again, you can see the bones. So again, this is a negative chest x-ray.

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Q. This is 7/1/85 on Joe Nunnally. Let's go now to 11/21/88, and let's look at a x-ray film on Mr. Nunnally taken at Methodist in Memphis. Tell us what we see now?

A. Here on the 19 -- November, 1988 film, you see significant changes. You see this is, again, a plain chest x-ray. You can see the left lung is, again, pretty normal in appearance. It's homogeneously black. The lower right lung field is more or less homogeneously black.

But in the right upper field, we have a large white mass, so there is a huge soft tissue dense tumor mass that is occupying that area. There is a little bit something here that may be a second sitting in here. Now, you can see the mass comes all the way to the lateral chest wall on the side peripherally.

You can see, however, that there is a little bit of black material still here. That black is still aerated lung. So there is some aerated lung in the middle here.

Q. Let me ask you some specific questions about 470 -- what's the number at the bottom?

A. 478.

Q. 478. Is the size -- does the size of

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this tumor tell you anything about its radiological appearance or features?

A. Yes, indeed it does. This is an enormous tumor. And to have survived with that size of a tumor, it is very likely that we're dealing with one of two types of tumor, either a lymphomatous type of tumor or a sarcomatous type of tumor. The other reason why this is very likely is because the tumor is of what we call equal density, homogenous density.

If it were tumors of other variety, other cancers, they have the probability of becoming chronic in the center. Because they outgrow their vascular supply in the center, and, therefore, the center of these large tumors become necrotic. So they have holes in the center, and in fact, they may present with neofluid levels in the center when we see them on this. But to have a tumor of this size, the likelihood by far is that it is a lymphomatous or sarcomatous type of tumor.

Q. Let me just ask you directly. Is the size of this tumor consistent or not with a squamous cell carcinoma?

A. It is not consistent with a squamous cell carcinoma. A patient with a squamous cell carcinoma

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of this size should be dead, should not --

Q. Have you, in your 40 odd years, 40 some

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odd years of medical training, have you ever seen a squamous cell carcinoma this large on presentation?
A. No, I have not.
Q. So is the size of this tumor consistent with a sarcoma?
A. Yes.
Q. You've talked about the appearance -- the homogenous density or the same density in the tumor. Is that consistent with a squamous cell carcinoma?
A. No, as I said earlier, with the exception of sarcomas and certain lymphomas, other malignant tumors, specifically for example, squamous cell carcinoma will outgrow their vascular supply.
Q. Which will mean what?
A. Which will mean they won't have blood flowing into the center of the tumor. And, therefore, the tumor becomes necrotic. And you end up with a hole in the center of the tumor.
Q. You said that a squamous cell carcinoma will outgrow its blood supply and leave the center of the tumor necrotic or dead. Does the same thing happen to a sarcoma or not?
A. It can, but much less likely. It happens

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to a sarcoma after treatment with chemotherapeutic agents, then you kill it off, but before treatment, usually not.
Q. Why?
A. Because the vascular supply of a sarcoma is very different from a carcinoma. And you don't have the constricting nature of the tumor on its endovascular supply.
Q. We talked about size, we talked about the density of the tumor. Is there anything else shown in this -- in this x-ray of Joe Nunnally, 11/21/88, that is significant to you in making a judgment, radiologically, where this is a sarcoma, or squamous cell or something else?
A. The other thing is squamous cell carcinoma, more likely than not but not always, will originate from the center. So the growth would be from the central location in the bronchus to the periphery and not from the periphery to the center, although this could happen.
The main thing is the size is inconsistent with it, the lack of cavitation or necrosis is inconsistent with squamous carcinomas. And the other thing, delineation, the margins are these tumors is different. They can spiculated.

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The intrusions of tumors into the adjacent tissues, and it looks like a cobweb, whereas sarcomas have a classically smooth presentation.
Q. Is there any significance or not to the fact that we don't see any shift in the mediastinum here, making a judgment sarcoma versus squamous cell carcinoma?
A. The main thing on that which I can show you better in the next one, is squamous cell carcinoma, even in much, much smaller variety would have nodes. And these are disseminated tumor particles to the hilar, to the regional nodes in this area. And to the next stage nodes which are

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preterenal nodes. We see no evidence of nodes here which is again inconsistent with a squamous carcinoma.

Q. You're going to have to help me on that. On nodes, you're talking about lymph nodes?

A. Lymph nodes.

Q. When cancer spreads, does it do it through the blood system and the lymph system at least some cancers?

A. It can do either. It can go through the blood vessels, or it can go do the lymph vessels. Bronchogenic carcinoma, squamous carcinoma

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classically disseminates the mass to the lymph nodes.

Q. Do you or not see any evidence in any of these films of any dissemination of this mass to the lymph nodes?

A. No.

Q. Is that consistent or inconsistent with the squamous cell carcinoma?

A. Inconsistent.

Q. How much inconsistent?

A. Highly inconsistent.

Q. What is your low --

A. Very highly. Well, even a small -- large one like that is in conceivable there would be no metastases. But even a small one, lesions of three centimeter and greater, that's one-inch lesions that's, you know, a lesion would be about that large on there, would have a better than 40 percent chance. Lesions of one-and-a-half have a better than 66 percent probability of nodes.

Q. What about a lesion of 15 centimeters?

A. Well, I can't answer the question, because I've never seen a lesion of 15 centimeters without it saying it's in but I would say it's in excess of 100 percent.

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Q. Let's look at this next diagram -- not diagram, x-ray 479, and there appears to be an area in the middle of this that has been highlighted in some fashion by -- by a special technique. What's the purpose of that?

A. This is simply a purpose of showing the area of the chorineber (sic), and showing whether or not there are large nodes there. This is an intensified picture of the hilar to show that here. You can see the main bronchi coming down like that. Then if there were nodes here, then this would splay, right, it would push it apart. And this is not the case. So the main thing, the main idea of that exercise is to show the area and show that there are no apparent nodes in this region.

Q. And do you see in Exhibit 479 any shift of the mediastinum?

A. There's no shift of the mediastinum.

Q. Now, I want to put up a record that was used earlier in the case. It's out of the hospital records. And it's a report by the radiologist, Dr. Routt, that was done 11/21/88. Would you --

A. I'm sorry.

Q. Would you read the opinion there, what he

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says?

A. The opinion is "large right upper lobe mass with two smaller right lung masses as described. This mass does not have the typical appearance or presentation of bronchogenic carcinoma and the possibility of a sarcomatous lesion is to be considered. The lesion" --

Q. Do you agree -- I'm sorry, I interrupted you. "This lesion is ready accessible to skinny needle aspiration biopsy."

A. Biopsy.

Q. Do you agree or disagree with the statement by Dr. Routt?

A. Yes, sir, absolutely agree.

Q. Now, next, another item that was used is a report by the pulmonologist, Dr. Blythe. It's dated 11/21/88, and read to the jury the impression of Dr. Blythe. Before you do that, do you -- do you know whether or not Dr. Blythe was the consulting pulmonologist in the case?

A. I believe he was.

Q. And this Dr. Alley, do you know whether or not he was the internal medicine doctor?

A. I believe he was.

Q. All right. Tell us what Dr. Blythe had to say as of 11/22/88?

A. In the impression -- "This is probably a sarcomatous lesion or lymphoma. I would think he would be more ill if this were an infectious process, and it would be unusual for a bronchogenic carcinoma to be this large at presentation, although with his heavy smoking history, this is still a consideration."

Q. All right.

A. "If the percutaneous aspiration biopsy is not productive, it can be repeat or we can go endobronchially at that time."

Q. Do you agree or disagree with Dr. Blythe?

A. I agree.

Q. He says this is probably a sarcomatous lesion or lymphoma? Does he not?

A. Absolutely.

Q. Have you looked at the records to see if Dr. Blythe ever withdraw, changed or took away or canceled this opinion that he gave as of 11/22 of '88?

A. Not to my knowledge of the records that were made available.

Q. All right, sir. Now, if there -- if there is a difference of opinion between the pathologist and the radiologist, what would you do in your hospital? Would you just say okay, or would there be some consultation to get further evidence?

A. No, there would be consultation. And usually it could be resolved by obtaining a second biopsy, usually a larger piece, chunk of tissue would be removed. The thin needle aspiration is extremely small, so it gives you only a few cells to base your opinion on.

We would then go to what is called a "gun

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biopsy" which is a spring loaded biopsy instrument which takes a sliver about the size of pencil lead. So there you have a good piece of tissue to look at. It's about as thick as the lead of a pencil.

Q. All right, sir. Now, the next item I want to look at with you is number 480, and just tell the jury very briefly what we're seeing right here, please, sir.

A. Now, this are then the CT slices as they're generated. And they relate, then, precisely, you have a number here, and this relates exactly to the same number. So you can look at the steering diagram, and you know exactly at which level each cut has been generated to allow you to orient yourself.

And you go -- in a chest CT, you go

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literally from the neck all the way down to the diaphragm. You can then continue, obviously and go to the abdomen. Then you have an abdominal CT. In each case, we generate steering diagrams, so we know what level we look at, and then we print it out.

Now, the printout in this can be in two fashions. It can be in a fashion that shows you soft tissue elements well, or shows you aerated lung well. And this is exactly the same picture, except the computer manipulates it slightly in density. But these two are exactly the same. They're generated from the same data. This simply allows us to either look at this area in detail or look at the aerated lung in detail.

Q. And now we've moved from x-rays to CT scan, have we not?

A. Yes, sir.

Q. Done by the Methodist Hospital on Joe Nunnally?

A. Yes, sir.

Q. Now, let's go to 481, and let's tell the jury what we see in 481.

A. This is cut number 14. So we know this was cut at cut number 14 level here, coming right through here. So we know which area of the tumor

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we're looking at.

Q. Get us oriented, though, because when I look at that, I don't really know what I'm seeing?

A. We are looking again from top now on a slice. We have cut the patient like a little thin slice. If you took a ban saw and cut him and cut him in a slice of one centimeter thick. What you see here is the sternum, the breast bone. And then you see the densities here, what we call white structure is dense.

This is all bone here. This is spine. And then we come here, and you see again the black area. This is normally aerated lung, normal in appearance on the left side. We also have normally aerated lung on the right side?

Q. What's the significance of that?

A. That there is no tumor in there. It's a normal aerated lung. We have some aerated lung toward the middle and posteriorly. But then we have the huge mass, that's the mass that we described to

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you that comes --
Q. Outline it with your finger, please?
A. -- from the side all the way to the periphery and comes to the middle here. But it doesn't reach the middle all the way. You can see

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there is some in the post aerated lung here. That proves that the lesion is growing in this direction and not from here to the other side. Because we have normal aerated lung here. The other thing that you can see here, the density of this area is about the same as, for example, the density here.
Now, the density that you see here represents muscle, so this is soft tissue density which is characteristic for tumor. The fact that there are no areas of difference intensity means that there are no areas of necrosis. And that, again, to a degree supports very strongly that you're dealing with either a lymphomatous or sarcomatous tumor, because squamous tumors would have areas of necrosis.
Q. Wait. Let me make sure I understand. You said squamous cell tumor would have areas of necrosis. How would it appear in this Exhibit?
A. It would have holes in it. It would have little black holes in it. It would not be of the same density.
Q. Now, you indicated that it was significant to you the direction of growth of this tumor from the periphery to the center as opposed from the center to the periphery. Why is that?

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A. Because a bronchogenic carcinoma generally grows from the center to the periphery.
Q. Now, is the shape of this tumor, and I'm outlining it with my finger, and I probably will do it halfway right at least. Did I get it about right?
A. Yes.
Q. Is the shape of that tumor, is that consistent with a squamous cell carcinoma or not?
A. Not really. Squamous cell carcinomas, again, it's much too the large for a squamous cell carcinoma. So it's really not consistent from the very beginning. But if it were smaller, it would have what we call spiculation. It has little teeth that stick out. Because squamous cell tumor grows into the adjacent tissue, whereas a sarcoma or lymphoma in particular has a relatively smooth margin.
Q. Okay. What -- what am I seeing right here? What is this, and what is this?
A. Now, these are the two main stem bronchi. Those are the tubes that come off the wind pipe and go to the lungs, the two main stem bronchi. And the importance of that is if there were nodes, which is a common finding, very common finding in squamous

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carcinoma, these nodes would be sitting here, and we really don't see any nodes here.
Q. Let me see if we can find a better explanation for some of the -- some of the anatomy is a little confusing to me, so maybe you can help

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the jury with --
A. To show you this better, this is the trachea, right, and here are these same bronchi coming down. Now, we have blown up the central area that I showed you there. We have done one additional thing. In the addition to the right stuff on the ribs and the vertebral body, you have additional white stuff here now, and we have introduced contrast material into the vascular system.

And we are now pacifying the heart and the big vessels. This, here, is for example is the aorta, the descending koruna of the aorta. This is the ascending koruna aorta, this is the pulmonary artery. Now, the reason why we do that is because that identifies that space here very well. And we can see if there's anything sitting in here. There is the koruna, the two main stem bronchi that we're talking about, and there is nothing sitting in this particular the area.

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Moreover, it is important to look at this here that happens to be the superior vena cava, the big vessel that goes to the heart. That, again, is pacified and perfectly nicely oval. It is not compressed. So there is no pressure effect in that area whatsoever.

Q. And if this had been a squamous cell carcinoma as contended, what would you expect to see in this the area?

A. I would expect to see nodes here, probably large nodes and nodes that possibly would push the on superior vena cava. One of the manifestation of squamous cell is patients blow up like a pumpkin and have a blue face because the blood can no longer return to the heart. It compresses the superior vena cava.

Q. Let me ask I know a dumb question. What are nodes?

A. Well, lymph nodes, we have two drainage systems. We have an arterial and venous drainage system, and we have a lymphatic drainage system. Both of them serve the purpose of moving fluid around. The lymph nodes are, if you wish to, a sewer collection post in the drainage system, so it doesn't go all the way through. They're a safety

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valve, and we catch inflammatory cells, for example, in the lymph nodes so we don't disseminate the inflammation and infection. So lymph nodes are very important. They also catch cancer cells. That's why they grow up and become metastatic, because they catch the cancer cells, so they the don't immediately disseminate.

Q. Did -- if -- you said if it was a squamous cell carcinoma you would expect to see nodal involvement, you would expect to see nodes.

A. Yes.

Q. What about sarcoma, would you expect to see nodes or not?

A. No, sarcoma is classically a blood borne dissemination, and we do not see nodes.

JUDGE CARLSON: Let's go ahead and stop

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here. This might be a good place for a break, ladies and gentlemen. You've been in place about an hour and 25 minutes. So let's take a short break.

(A short break was taken.)

MR. ULMER: May I proceed, Your Honor?

JUDGE CARLSON: Yeah.

Q. (By Mr. Ulmer) Dr. Lang, let's conclude our discussion of -- of the large tumor in the right upper lobe with just a few questions for you. I'd

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like to ask you, first, you have indicated that squamous cell carcinomas are associated with smoking, I believe.

A. That is correct.

Q. And sarcomas are not associated with smoking?

A. That is correct.

Q. I want to ask you, sir, if the size of the tumor in the right upper lobe is consistent with a squamous cell carcinoma?

A. No. It's too large.

Q. Is the size of the tumor consistent with a sarcoma?

A. Yes, it is.

Q. Is the density, the homogenous density, the fact that there's no necrosis in the center of the tumor, is that consistent with a squamous cell carcinoma?

A. No, it's inconsistent.

Q. Is it consistent or not with a sarcoma?

A. It's quite characteristic for a sarcoma.

Q. What about the -- we talked about the mediastinal shift, the central structure in here. Would you expect to see mediastinal shift if you had a squamous cell?

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A. Yes, because it would be central, it would tend to shift it.

Q. So the fact that there is none is not consistent with squamous cell?

A. Not consistent, because there is no shift.

Q. Is the fact that we have no mediastinal shift consistent with a sarcoma?

A. Peripheral sarcoma, yes.

Q. The fact that we had no noticed involvement, no inflammation or cancer in the lymph nodes that are located immediately adjacent to this mass, is that consistent or inconsistent with squamous cell carcinoma?

A. It is inconsistent, because squamous cell carcinoma would have those of metastases, not inflammation, necessarily.

Q. Is the fact that we have no nodal involvement consistent or inconsistent with sarcoma?

A. It's quite consistent with it.

Q. The direction of growth of this tumor, is that consistent with the squamous cell?

A. It is not.

Q. Is it consistent with sarcoma, the direction of growth?

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A. Yes, it is.

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Q. And finally, is the shape of this tumor consistent with a squamous cell carcinoma?
A. No, it is not spiculated or has little protuberances. It is not consistent with it.
Q. Is the shape of this tumor consistent with a sarcoma?
A. Yes, it is.
Q. Now, Dr. Lang, let's turn our attention to the tumor in the right middle lobe just for a very few minutes. Will you do that with me?
A. Yes.
Q. All right, sir. I want to put up 484, and if you will --
A. This, again, here is slide number 18, so you can see, this is slightly lower now at the level of 18 we're cutting through here a slice.
And on this one, you can see this is the different mode. I told you earlier, we use two modes of presentation. This is the so-called pulmonary mode of presentation. That's the entire chest wall, everything is kind of white here. The heart is white, the mediastinal structures are white, and even here is some diaphragm coming through.

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Now, the important thing is the left lung is black. The right lung is mostly black, but there is a typical mass in here, the appearance of it we called it a cannon ball appearance. It looks like an old cannon ball, and it does not have spiculation. It has little warts, little bitty rounded warts, but looks like old fashioned Civil War musket ball or cannon ball. We call this a cannon ball lesion which is fairly characteristic for metastatic lesions to the lung.
Q. When you say metastatic lesion from the lung --
A. Not from the lung, I said to the lung.
Q. Metastatic lesion?
A. Metastatic lesion to the lung. That means the primary, the original tumor is somewhere else. Could be anywhere, could be in the stomach, could be in the bowel, could be in the bladder, could be in the prostate, could be just about anywhere. Any tumor that gives you metastases to the lung could present with this type of cannon ball lesion.
Q. So is it or is it not your opinion that this appears to be a metastatic lesion from outside the lung?

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A. Yes, it is.
Q. What are the most likely sources for that metastatic lesion that we see here?
A. The most likely source for any metastatic lesion of the lung in these circumstances would be bowel carcinoma from the colon, and the female breast carcinoma.
Q. What about the kidneys, is that a source?
A. I'm sorry, sir?
Q. The kidney, is that a source?
A. The kidney is a source, but the kidney tumor, the primary kidney tumor is much less

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commonly seen than breast carcinoma or bowel carcinoma. So while it is very consistent or compatible in appearance with tumors from the kidney, only about two percent, where breast tumors are much more common.

Q. What about from the pancreas?

A. The pancreas likewise will give you classically that type of lesion if it metastasizes to the lung.

Q. Did you read Dr. Alpert's deposition and rely upon it in reaching your opinions in this case?

A. Yes, I did.

Q. Did she or not describe this as a clear

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cell type?

A. She described it as a clear cell type, and the most common clear cell type is a kidney tumor that is metastatic. So the most commonly clear cell would be kidney. But there are other clear cells. It can be a clear cell tumor that originates from the pancreas. It can be a clear cell tumor that originates from the thyroid. There are be potentially other it clear cell origins.

Q. Where do they most often originate?

A. Most commonly in the kidney.

Q. Let me back up and make sure the jury is oriented. We are not talking about the large mass in the right upper lobe. We are talking about a smaller tumor that's located in the middle lobe, are we not?

A. That is right.

Q. And is it your opinion or not that this smaller tumor is a metastasis from somewhere else?

A. Yes, it is.

Q. And is it your opinion or not that it metastasized from an extra pulmonary or outside the pulmonary area?

A. It is most likely, yes.

Q. And the most likely, considering that

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this is a man, where would be the most likely source for that metastasis to the lung?

A. It most likely would be from the kidney.

Q. All right.

A. Well, no, the most likely, the appearance of the mass, would depend on what we're dealing with. We're dealing here with a male, so the most likely would be a colon carcinoma, metastatic, colon.

Q. Was there a definitive and positive way to know where this tumor came from?

A. Yes. Since we know what this tumor is histologically, it's a clear cell, it really suggests three possibilities as high possibilities, that's kidney by far the most common one, thyroid the second most common one, and pancreas would be the third most common one. So with this in mind, we would then get together and further look in these three areas to see if there's a tumor there.

Q. Well, would an autopsy have resolved the issue or not?

A. Yes.

Q. Now, do clear cell -- do the clear cells

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arise as a primary in the lung?
A. No.

Q. All right, sir. Now, did you -- did you look at the CT and other radiological evidence from other parts of the body to try to make a determination as to where this tumor came from?
A. Yes, there were additional CTs of the abdomen. We have here a cut of the abdomen. Now, that cut is actually a little lower than my table here indicates. It would be at about this level down here. So we're a little bit lower now. We don't have a scan ground for that area. But that cut would be about this level, about this level of the abdomen.
MR. MERKEL: Excuse me, Dr. Lang. May we approach, Your Honor?
THE WITNESS: Sure.
MR. MERKEL: Pardon me for a minute while we take something up with the Court.
(Off-the-record discussion.)
Q. (By Mr. Ulmer) Dr. Lang, you can step back down.
JUDGE CARLSON: Step back down.
Q. (By Mr. Ulmer) All right. We're looking at Exhibit 486, and you were telling the jury, I believe, about where this is located on the body.
A. This cut was approximately through this

section of the abdomen. (indicating.) So what we see on this specific part, we see again the lower parts cut along here, the white area here, is, again, a bony structure, the spine. And then we see a fairly large, relatively light area over here. That's the liver. We see another relatively light area over here that is the spleen.
JUDGE CARLSON: Excuse me, Doctor. You may need to speak up a little bit. Not only the jury can hear you the court reporter has to hear you, too.
A. The relatively light area is the spleen, denser white area is the upper part of the kidney. The reason that is denser because it's concentrated dye we have injected. You see the white area here, that is the passive aorta, major blood vessel, and when you look at this, you can see again there is a white area going forward. That white area is the cilia artery which is the main blood vessel we have to supply kidney, spleen and stomach, and there's a direct vessel going over to the liver.
I'm sorry, I said kidney, I meant liver, spleen and stomach, and you can see that there's a direct vessel straight going over toward the liver that is the so-called pan artery, and then there's a

vessel going over to the spine, but that vessel doesn't go straight. It should go from here over to here. It's behind the spleen. It doesn't do that. I'm sorry. Can you see it? It doesn't go straight, rather in there it kind of bends to the back. So there must be a reason why it is bending to the back, and the reason for that is that there appears to be a mass in this area that you see.

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Q. (By Mr. Ulmer) What is that area?
A. That area is the region of the body and tail of the pancreas. So there appears to be a mass in the region and body of the tail of the pancreas. Can I use the other one?
Q. You have prepared a medical illustration that's anatomically correct, and based on Exhibit 486.
A. I think this will perhaps show it a little bit easier. That's simply the same thing drawn out. See here your liver, you see here the spleen. You see here the upper bowl of the kidney. Now, here very importantly in red you see the aorta. And from the aorta goes the vessel to the front, that is the ciliac artery, and that gives off two vessels, one to the liver, the other to the spleen. And the third one happens to go to the stomach,

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which we don't have on here. But you can see instead of going straight where it's supposed to go in here, it bends backwards.
So on basis of the spleen, basis of this bend, we can say it has to be something sitting in front, otherwise it wouldn't bend backwards, and that implies we're dealing with a mass in the pancreas.
Q. Do you have an opinion to a reasonable degree of medical certainty if there was a mass in the pancreas?
A. Yes.
Q. And what is that opinion?
A. That there was a mass.
Q. Do you know whether or not the mass that is shown in Exhibit 486 was ever appreciated or found on -- on review by the Methodist Hospital? Was this mass ever recognized by the Methodist Hospital?
A. Well, it's obviously there. This is their film. They didn't particularly describe it. But yes, it's on their film.
Q. All right, sir. Do -- we talked about sarcomas, which are not related to smoking, and squamous cell carcinomas which are related to

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smoking in this large mass and right up below. We've now in the last 15 minutes focused on this cannon ball shaped metastasis in the middle lobe. Is it your opinion or not that this was a metastasis from some source outside the lung?
A. Yes.
Q. And you had indicated earlier that there were a number of different the potential sites, based on what's shown in Exhibit 486, do you have an opinion, based upon a reasonable degree of medical certainty, as to whether that mass, the right middle lobe came from the pancreas?
A. This is the most likely thing. We have no finding of another abdominal mass, bowel mass. We have a finding that there's a mass here. So this is probably the primary for the metastatic lesion in the right middle lobe.
Q. And we talked about Dr. Alpert's description of this as a clear cell type cancers, do

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clear cell type cancers arise in the pancreas?
A. They can.
Q. Do they arise in the kidney?
A. They very commonly arise in the kidney.
Q. Is that sometime called renal cell cancer?

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A. Yes, renal cell carcinoma, renal cell and granular cells, and bronchocytic cells.
Q. What -- for pancreatic cancer, what is the likely patient outcome for pancreatic cancer?
A. It is almost uniformly lethal, the patient dies, moreover, the survival is extremely short, survival once a mass of this size is diagnosed of approximately 6.2 months.
Q. I only have just a few more questions for you, Dr. Lang. Joe Nunnally, at diagnosis, I believe, was 36 years of age, and his death was 37 years of age. Is it rare for a person of that age to have cancer in the lung?
A. Yes.
Q. Describe the rarity or the lack of rarity of that.
A. Well, again, it depends what you call cancer in the lung. If it's a metastases, for example, from a tumor metastases, it is not rare. Because that occurs mostly in younger individuals, you would find but primary lung cancer would be extremely rare.
Q. Let me ask a better question, then. Is it rare or not to have a primary lung cancer in the lung at 36 to 37 years of age?

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A. Yes, it's extremely rare.
Q. On the order of? When you say "rare," that means different things to different people. Have you ever -- have you ever had a patient in your 40 some odd years present with a primary lung cancer at 37 years of age? When I say "primary," I mean starting in the lung.
A. No.
Q. All right, sir. Now, we talked about metastasis, that is where a piece of cancer like an embolism breaks off and travels through the blood or lymph system somewhere else. Is the lung a common site for metastasis?
A. The lung is one of the common sites; the liver is the other common site.
Q. Why is the lung a common site for metastasis?
A. Because it is, in essence, a filter. When the cells get disseminated in the bloodstream, they have to be circulated to the lung. Because our entire blood goes through the lung to be oxygenated. Now, the small vessels in the lungs where the exchange for the oxygen takes place can very easily result in stopping these tumor cells there.
So once they stop them there, then the

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tumor grows there. So it's like a filter. You're sending these cells through a filter. And the two filters we have in the body or the three filters is the liver, where the blood gets filtered through,

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and the cells get stuck, and more metastases, and the lung where the exchange for oxygen takes place, and the lymph nodes, and those are the three filter areas where we see metastases.

Q. Final two questions. Do you have an opinion based upon a reasonable degree of medical certainty as to whether or not the large mass in the right upper lobe was a squamous cell carcinoma?

A. I do not think it was a squamous cell carcinoma.

Q. Do you have an opinion as to what it was most likely?

A. Most likely a sarcoma.

Q. Do you have an opinion based upon a reasonable degree of medical certainty, as to whether the smaller tumor in the right upper lobe was from the lung or metastasized to the lung from some other site?

A. Most likely metastases to the lung.

MR. ULMER: Tender the witness's, Your Honor. Before I tender the witness's, Your Honor,

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let me offer into evidence certain of these exhibits. We will not offer the medical illustrations, but -- and not to slow things down, if I could just provide the numbers now, and maybe let Mr. Merkel proceed, then I'll substitute smaller copies into the record. Would that be permissible?

JUDGE CARLSON: Yes, sir.

MR. ULMER: We offer Exhibit AWN-477 and AWN-478, 479, 480, 481, 482, 484, 486. And we would like to offer a copy of Dr. Lang's CV which is AN-001128, and finally, we offer 474 as well. I overlooked it.

MR. MERKEL: The only one we object to, Your Honor, is 482 which has medical illustration superimposed on it.

JUDGE CARLSON: Yes, sir.

MR. MERKEL: This one right here. Object to that.

JUDGE CARLSON: I'll permit it to be marked along with the others. The objection will be noted. The exhibits will be marked and received into evidence.

CROSS EXAMINATION BY MR. MERKEL:

MR. MERKEL: Proceed, Your Honor?

JUDGE CARLSON: Yes, sir.

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Q. (By Mr. Merkel) Dr. Lang, other than Mr. Ulmer's hand written job here, I'm kind of fascinated by the quality of your defense boards here. Did you have these made or --

A. Yes, sir, they were made in New York City.

Q. New York City. How much did they cost R. J. Reynolds to get this whole collection made?

A. I didn't pay for it.

Q. Well, $10,000 or --

A. Counsel may have the figure. I -- I have no idea. I selected and approved the drawings. And there was a medical illustrator in New York City who I approved the drawings and worked out the drawings with him. He presented a bill not to me, but he

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presented it to the attorneys. So they paid for it. I have no idea what they paid for it, sir.

Q. Did you go to New York City and work with him on how you wanted all of this displayed and demonstrated?

A. It so happened that I was a guest professor at SUNY, downstate medical center, and it was convenient for me to meet in his office in New York City. I happen to be up there fairly frequent, and I met him up there. That is correct.

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Q. Let's talk a little bit, Dr. Lang, about cancer in general, and metastasis in particular. Am I right that the primary cancer comes before the metastasis?

A. Yes, sir.

Q. And how long does it normally take a cancer to grow enough to the point that it metastasizes and appears somewhere else?

A. This is extremely variable. But the presence of metastases does relate to the size of the primary tumor. The size of the primary tumor relates to the growth rate, which is different for different tumors.

Q. Well, you've been telling us throughout all of this what the classic this is or the generally appearance of this, that and the other. There's nothing really -- all tumors are very different in how they appear, and how they metastasize and where they go; is that not true?

A. They have a fairly characteristic what we call "pattern" on the basis of which they identify themself, yes.

Q. But they have a lot of variability, too, don't they, in fairness, Dr. Lang?

A. They have variability, but there is some

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type specific nature to tumors. And we call it a signature pattern of a tumor. And it is one of the classical things that you teach young physicians to recognize. That a tumor with a certain appearance very likely is that type of tumor that foreshortens the amount of examination that is necessary to establish a definitive diagnosis. Because it leads you in the proper pathway.

Q. Well, using that criteria again instead of telling me variable, how big they have to be, what is the classic signature, how big does a tumor have to be in the order to metastasize?

A. Generally very small. We see tumor metastases with tumors of a half an inch, certainly tumors of the size of one inch have a very high probability of being metastatic. But there are tumors of a half an inch size that are already metastatic.

Q. Now, if we're going again by the classic norms, Dr. Lang, how long does it take a tumor to go from whatever size it starts to 15 centimeters?

A. Just depends on the doubling time of the tumor. Some tumors have a faster doubling time. Others have a slower doubling time. For example, if you have a slow glowing tumor, a carcinoma of the

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prostate, it would take enormously long to grow to that size. On the other hand if you take, for example, a very malignant cancer of the female organs, cora carcinoma, it takes a half a year, six months, and they grow to enormous size.

Q. Well, we don't have a female here.

A. Correct. That's why I say each tumor has a very specific pattern by which we can identify it, it's characteristic in growth speed. It's characteristic in contour appearance. They're very characteristic.

Q. Let's talk about the possibilities in Mr. Nunnally's case. You just give me all the types of tumors you think it could possibly be, and then I want to know how long it took it to grow from origin to the 15 centimeters in each instance.

A. Well, we see --

Q. Typically, again, and I understand there's variability, but you've been giving Mr. Ulmer typical all afternoon, and that's what I'm like looking for.

A. Precisely, sir. We have two reference points. We have reference point of 1985 where we have a chest film, and I see nothing on it. We have a reference point of 1988 three years later where we

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have an enormous tumor there. This mandates that this is something that grows very rapidly. And sarcomas, classically can do that. Now, lymphomas can do that. So the two probabilities for that would be a sarcoma or lymphoma to grow that fast.

Q. Take them apart. How long does it take a sarcoma to go from nothing to 15 centimeters?

A. That can be achieved certainly in a period of two-and-a-half years, no problem.

Q. Two-and-a-half years. All right. How about a lymphoma?

A. Could even be less than that.

Q. Sir?

A. Could be less than that.

Q. Well, two years, year-and-a-half, best --

A. Year-and-a-half, two years.

Q. Okay. And it could also be a -- a squamous cell carcinoma, I suppose?

A. Squamous cell carcinoma, number one, doesn't grow that fast.

Q. Well --

A. And number two --

Q. Excuse me just a second, doctor -- I'm not asking --

MR. ULMER: He's trying to finish.

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MR. MERKEL: Trying to save time.

MR. ULMER: He's trying to finish his answer, Your Honor.

JUDGE CARLSON: Go ahead and answer the question.

A. A squamous cell carcinoma does not grow that fast, number one. And number two, a squamous cell carcinoma will kill a patient much before it reaches the size. Because a squamous cell carcinoma has a very high probability of early metastases to lymph nodes, and the patient would long be dead

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before it reaches this size.
Q. (By Mr. Merkel) Well, I was not asking you, Doctor, for your opinion about whether it was or whether it wasn't. I'm saying hypothetically speaking how long would it take a squamous cell carcinoma to grow to 15 centimeters?
A. I have no reference for that. There is nothing in the literature that I know of that gives you reference that a squamous cell carcinoma has grown to 15 centimeters in a live patient, and it doesn't grow in a dead patient.
Q. Okay. Any bronchogenic carcinoma, Dr. Lang?
A. 15-centimeter bronchogenic carcinoma, any

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bronchogenic carcinoma would, in great likelihood, kill the patient before it reaches 15 centimeter. Number one. Number two, a bronchogenic carcinoma by nature of the blood vessels that this tumor has would have loss it's blood supply and would have become necrotic. And the patient would have acquired infection or tumor load, and he wouldn't be alive. I have no reference point to give you, because we don't see them that large, sir.
Q. I'm confused. Is Dr. Joseph Blythe here when he says, "It would be unusual for bronchogenic carcinoma to be this large at presentation, although with his heavy smoking history, this is still a consideration," I mean, is he just dumb as dirt when he says that?
A. I thought he says it's unusual.
Q. I know, be he says it's still a consideration, and you seem to be telling us this is just ludicrous.
A. Well, would you -- would you explain the term "unusual" to me. Unusual means it isn't encountered, right, he isn't saying --
Q. It's not the common, I agree with that. When he says --
A. What is your percentage of unusual? Do

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you have percentage values of unusual. I would say in our language means generally less than two percent. This is what you call unusual.
Q. Well, then why is --
A. It is anecdotal or unusual in medical terminology or -- unless you offer me a different question, I don't know how to answer your question.
Q. You say you're familiar with the records?
A. Yes.
Q. What he says, "It would be unusual for bronchogenic to be this large at presentation."
A. Right.
Q. "Although with his heavy smoking history, this" -- being bronchogenic carcinoma -- "is still a consideration." Now, my question to you, is he an idiot, or is it still a consideration?
A. No, sir, he says it is unusual that a bronchogenic carcinoma is that large at presentation. Now, the second portion of the sentence, I interpret that with heavy smoking history, there is occurrence of bronchogenic carcinoma.

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I agree with both of his statement, heavy smoking history, high occurrence, high, certainly a high probability of bronchogenic carcinoma, first

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portion it's unusual that bronchogenic carcinoma is that large as presentation. It means less than two percent probability in medical jargon.

Q. Unusual is less than two percent?

A. That's what we call unusual.

Q. I see. Where is that contained in some medical work, Dr. Lang?

A. Sir?

Q. Where is that definition of that word contained in some medical work you could give me to look up?

A. This is something that we use for reporting. And everybody knows that when we use the term "unusual" or "anecdotal," it occurs in a rare instance. "Rare" we define is less than two percent. It still can occur.

Q. Let's say for the sake of my question, then, if you'll humor me, this is one of those two percent shots. How long can it take for a bronchogenic carcinoma to grow to 15 centimeters if it was one of those two percent chances Dr. Blythe is looking at?

A. I would -- if a patient could survive that amount of tumor load, we are talking here of an enormous tumor load. If he could survive it, I

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would say it would have to be probably in excess of multiple years. I don't know how many.

Q. Again, two?

A. Sir, I just tried to explain to you, I can't give you a scientific answer, because there are no data from that.

Q. All right.

A. All the patients that have a tumor that large we find at autopsy, they are dead. So we have no data. I know of no data that the I can offer you for that. You're giving me a supposition that is deprived of any scientific basis.

Q. I see. Well, if it's, as you've opined, a metastatic tumor that's gone to there. And if it took it two-and-a-half years to get to this size, assuming as you say, it's a sarcoma, then that means it had to be a pancreatic tumor more than two-and-a-half years previously, didn't it?

A. I'm not saying this is a metastasis from the pancreas, sir. I'm saying this is a sarcoma. I think the second lesion in the middle lobe was what I believe I said, I hope I didn't misrepresent it, was the lesion that I think is from the pancreas.

The lesion up there is so large that there are only really two points that the come in

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consideration, that is lymphoma or sarcoma. The lesion in the middle lobe is what I -- I hope I didn't confuse you -- but the lesion in the middle lobe is the one that I think is a metastatic lesion from the pancreas.

Q. So we just coincidentally, at the same time we've got a pancreatic cancer we've got this

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sarcoma that's been growing there two-and-a-half years, and that just came from two different places?

A. Yes, sir, coexisting tumor is recognized in the medical literature.

Q. Does the medical literature recognize, Dr. Lang, that tumors can metastasize from one spot in the lung to the same lung?

A. Yes, sir, they can.

Q. And they can go from one lung to another lung?

A. Yes, sir, absolutely.

Q. And does the medical literature recognize that you can have bronchogenic tumors that don't go into lymph nodes?

A. Yes, sir.

Q. And this tumor, if it were clear cell, the small one, as Dr. Alpert said. And in fact, what Dr. Alpert said is that was not diagnostic of

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anything. But it had some clear areas in the cell, and that those could come from the lungs, or the pancreas, or the liver or the stomach, I believe she said, did she not, Doctor?

A. I don't recall the precise wording. I have it as clear cell.

Q. Did you read her deposition, Doctor?

A. Yes, sir.

Q. Do you recall it when you were testifying about --

A. Yes, sir.

Q. -- what she said about clear cell?

A. Yeah. But please refresh my memory. I have it as clear cell, and that's as close as I could come.

Q. Well, in fact, she said that clear cell wasn't even a type of cancer, did she not, sir? May I approach, Your Honor?

JUDGE CARLSON: Yes, sir.

Q. (By Mr. Merkel) She first touches on it -- well, this may not be the first. Right here, you gave an answer that clear cell can come from the lungs, the kidneys or stomach I believe was another area that you suggested. "In the first place, is there any evidence that any of the cells were clear

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cell carcinoma in any of the specimens?" She says, "Many of the cells in the second nodule have a clear appearance, so when you call it clear cell carcinoma, you're not saying very much. You're just saying that the cells have clear cytoplasm, and there can be several causes for that. It does not -- there can be several causes for that." "Among those, what would the causes be for that appearance?" She says, "A lot of glycogen can cause clear cell appearance, a lot of fat can cause clear cell, a lot of ribosomal --

A. Dilatation.

Q. "dilatation can cause a certain granulation in clear cell appearance." Question: "So the existence of cells with clear cell appearance, is that in any way diagnostic of this being clear cell carcinoma, that alone." Answer: "Your question suggests to me the use of the word

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clear cell. It's not clear to me. It sounds like you're using that word as if clear cell carcinoma has a particular significance." She then goes on to say, "It's a descriptive terminology, and when you have something that looks clear and appears to be a carcinoma as opposed to a sarcoma or lymphoma, the fact that it's clear is a descriptive word and

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allows you, then, to pursue, if you choose, to the refigure what is causing the clearness of those cells. We proceeded here with PAS stains and found that there was glycogen." Now, am I not reading that correctly, Doctor?

A. Yes, you're reading that correctly. I am not certain that the inference that is given from it. She's describing a clear cell.

Q. What she --

A. Clear cell carcinoma is a descriptive -- is a descriptive entity. Now, if you wish to argue with the pathologist on the various appearance of clear cell, please do so. I won't pick you up on that. I can say one thing. If you have fat in the cell, okay, we can stain fat. We have specific stains for that. There are specific stains for glycogen.

Q. She did that, Doctor.

A. So you can process that. I don't know whether she -- I saw no reference that she stained for fat and found or did not find fat. Refresh my memory on that. I don't know what fat stains she did.

Q. All right, Doctor. Did she say right here, "So the existence of cells clear appearance is

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that in any way diagnostic," she says again, "I seem to be suggesting that she's calling it clear cell." She says, "It's a descriptive terminology, and when you have something that looks clear, you can test. We pursued it here with PAS stains, tests for glycogen."

A. That's for glycogen. I'm trying -- you just quoted me a minute ago other possibility, namely fat, Sudan 3 if you the don't know it is the proper stain for fat. Did she do the Sudan 3 stain? I'm asking you.

Q. Did she do a glycogen stain, Doctor, and find it to be positive in the small tumor?

A. She did not find anything positive on glycogen.

Q. You're saying -- excuse me. Let's don't talk over each other.

A. Okay.

Q. Are you telling the jury that she did not find glycogen in the small tumor?

A. She did a glycogen stain.

Q. Did she find it?

A. She did.

Q. Was it positive or negative?

A. Apparently, it was positive.

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Q. Apparently. Have I convinced you of that, or do you remember that, Doctor?

A. Well, let me remind you, sir, that she

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gives three different options, okay. She calls it clear cell which for me as an oncological physician implies a clear cell tumor. She gives a number of possibilities for clear cell. To illusivate on the clear cells, and I'm not a expert staining in pathology. She gives on stain which goes to glycogen. I'm just telling you, another sustain, classical stain that's used today is Sudan 3 that's used for fat. I know of no reference that she stained for fat. You know, what are you saying? I don't know.

Q. Well, I'm trying to find out partly what you know, Doctor. Did she do one stain or two stains for glycogen?

A. Apparently one stain.

Q. You don't have to do two stains to determine glycogen?

A. There are multiple different staining techniques. I'm not an expert on the staining techniques. I know the basic stains that are used. There are many very complex stains. There is modality of electronmicroscopy to further illusivate

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on that. As far as I know, there was no electron microscopy done on this specimen, so that wasn't processed this way. The reason why it wasn't, I cannot tell you. I don't know.

Q. Let's try this, Doctor, to find out whether there's glycogen there, do you have to do a PAS stain first, and then a PAS stain with digestion to see if the glycogen or color disappears?

A. I believe that's correct.

Q. So there's actually two stains to determine that, aren't there?

A. I recall of one. She may have done two. If you say so, I certainly accept it. But both of them are glycogen stains. I do not think she did a Sudan 3 stain or did she? Refresh my memory. I may be defective in my memory.

Q. The jury has heard all what Dr. Alpert said, Doctor.

A. Okay.

Q. We'll worry about that later.

A. Okay.

Q. As far, Dr. Lang, what you're saying here, if I understand it now, only the small tumor metastasized.

A. I'm sorry, sir.

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Q. Only the small tumor what you're telling the jury, you think metastasized from this pancreas that had the primary in it?

A. I said that the pancreatic lesion metastasized to the middle lobe.

Q. The small tumor in the middle lobe?

A. The small is a metastasis, yes, sir.

Q. The other one is not now, so we won't be confused anymore about that.

A. No.

Q. The big one didn't metastasize?

A. The large one is more unlikely to be a metastases, moreover, there was a suggestion it was sarcoma, histopathologically, too.

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Q. Unquestionably, Doctor, if it had been a metastasis, and it had grown to that size and it start in the pancreas as you suggest, Mr. Nunnally would have been dead from the pancreatic lesion long before it got to 15 centimeters?
A. I fully agree with you.
Q. And the fact the longevity of pancreatic cancer is as low as three months from diagnosis, isn't it, sir?
A. Three to six months, yes.
Q. And does pancreatic cancer show any other

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symtomology as it advances and the patient continues to be eaten up and killed by pancreatic cancer?
A. The location an as you indeed imply, it does. If the tumor is in what we call the head of the pancreas, it will obstruct the bile deducts, and the patient will present with jaundice.
Q. Do we have any of that in the record, Doctor, anything that shows he's jaundiced?
A. No, the tumor was in the tail of the pancreas. It would not obstruct the bail deducts, because they enter in the head of the pancreas, and it there would be no opportunity to obstruct them.
Q. What were the symptoms that it was in the tail? How would the patient or doctor the know that's where it was?
A. Frequently pain is the first symptom that these patients experience.
Q. Can you find anywhere in the record where he complained of pain in that area of his abdomen?
A. Not -- not particularly no, sir.
Q. And if he was dying of pancreatic cancer, he should have tremendous pain there, shouldn't he?
A. The majority of patients I have seen had severe pain, indeed this is correct.
Q. You told us, Doctor, what "unusual" means

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in your medical vernacular. What does "impression" mean?
A. That's a summary of the component of the report above. You summarize it.
Q. Well, does it mean that's what you think it could be at that time?
A. Yes.
Q. It's not a diagnosis yet, is it?
A. No, it's not a definitive diagnosis. It's the impression of the information you have above summarized.
Q. And if you go through the process in a hospital with a specialist consulting and all of the team getting together like you said. This comes way before diagnosis, doesn't it?
A. That is correct, sir.
Q. And what was the diagnosis in this case at Methodist Hospital in Memphis, Dr. Lang?
A. Well, the diagnosis was an inoperable tumor.
Q. What kind, Doctor?
A. Their initial diagnosis, I think, on basis was a sarcoma. The radiologist read it as a probable sarcoma.
Q. I thought this was an impression, Doctor.

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A. This is the pulmonologist. There is a radiologic report from the same hospital.
Q. Let's look at it. These are your two boards.
A. Uh-huh.
Q. Now, this is an opinion.
A. Yeah.
Q. And it says the mass does not have the typical appearance of presentation of bronchogenic carcinoma. Now, what does "typical" mean?
A. Typical mean --
Q. What percentage is that?
A. Typical is high percentage, which we express usually in the range of greater than 66 percent, that's high percent.
Q. 66 percent. Okay. So he said it doesn't look like 66 percent of them. And the possibility -- now, that's less than 50 percent, I guess, possibility, isn't it?
A. That is correct. Possibility would be less than 50 percent.
Q. And the possibility of a sarcomatous lesion is to be considered.
A. Yeah.
Q. Now, this was all done on 11/22?
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A. Yeah.
Q. Right? And this impression was done on 11/22, correct?
A. Yes.
Q. And by 11/29, the date of discharge, what was the diagnosis, Doctor? Number 1 right here.
A. It was expressed as squamous cell carcinoma.
Q. Okay. Which of those impression, opinion and diagnosis carries the most medical weight in health facilities all over this nation?
A. The discharge diagnosis should incorporate all the diagnostic criteria. However, if there is a disparity in the expression of probabilities of diagnosis, then additional tissue should be obtained until you can solidify the diagnosis that's usually the procedure in every major hospital. However, if the hospital feels that this is adequately expressed and, then this is listed as the discharge diagnosis.
Q. Do you see anything here, Doctor, that the Methodist Hospital in Memphis is acting like a bunch of incompetent turkeys or something?
A. No, not at all.
Q. So would you assume that Dr. Blythe who
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once thought his impression was that it was probably a sarcoma, and Dr. Routt who once said that it was the possibility of a sarcoma, do you think they all got in teamwork and conjunction with the treating physicians and came to this diagnosis?
A. I don't know that. I would certainly feel that their diagnosis was much more reasonable than the data that they had. And in the institutions that I have worked in, we would have pursued it much further, because you have two

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physicians who expressed the probability diagnosis that is very reasonable and explains the thing very well and would have deserved to be pursued.

Now, on the other hand, if there is something that came up that made them come to this diagnosis, then, indeed, you enter it as your final diagnosis.

Q. We would certainly hope, wouldn't we, Doctor, that the medical profession would pursue it further to reach the right result if they were trying to save a man's life --

A. Oh, absolutely.

Q. -- than if they were in Court trying to testify for a Defendant that it was something other than the medical record said?

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A. Well, I don't know. I'm looking at the medical records, too, unless you disenfranchise the radiology report that is a medical record. I felt that is a medical record.

Q. Well, there's the pathology report, doctor. What does it say it is?

A. "Poorly differentiated squamous carcinoma."

Q. And that is on the date 11/23, the next day after these things.

A. Uh-huh, yeah.

Q. After they got the pathology.

A. Yeah.

Q. What does this one say on 11/23, Doctor?

A. "Poorly differentiated squamous carcinoma." So they copied the report from that, which is reasonable.

Q. What does this one say on?

A. If you allow me to help you, that's a billing code. This is where the billing code is printed out.

Q. That would have been done at the end of the case, I suppose, 11/29, then.

JUDGE CARLSON: Give me just a minute, do you need to check on something?

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COURT REPORTER: I need to check my paper.

Q. (By Mr. Merkel) January the 13th, 1989, Dr. Lang, what was the diagnosis then, nearly a month later?

A. The same diagnosis, for obvious reason, once you have the diagnosis entered as final diagnosis, you copy it until it is altered for whatever reason.

Q. And when he got to Houston, this was diagnosed as squamous cell carcinoma. This is in March of '89.

A. Right.

Q. What was he treated for, Doctor?

A. Well, I think the treatment, basically, was for a lesion that was considered inoperable, and the treatment was very reasonable.

Q. Does treatment for sarcoma differ from a carcinoma, Doctor?

A. In most instances, yes, I would probably have deployed chemotherapy earlier. But this was a

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very large lesion. And what the physicians did, namely to use radiation therapy in order to shrink it down was a perfectly reasonable attempt.

Q. Well, going back to your "usuals" that

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you've been testifying to Mr. Ulmer about, what's usually done, was this treated as a sarcoma or carcinoma, Doctor, in the usual context?

A. The first treatments, the treatment at Methodist --

Q. The radiation treatment.

A. The radiation therapy in Memphis I think was certainly directed as a treatment for a large anoplastic carcinoma.

Q. Not the sarcoma?

A. No, sir, I don't think so.

Q. If we put Mr. Ulmer's chart up here, and if we put another column up here, that said, "treatment," was it consistent with squamous cell, we would say yes. And sarcoma, we would say no?

A. Not entirely. I think it was more consistent and more appropriate for large carcinoma, yes, sir.

Q. Would you use chemotherapy with large sarcomas, Dr. Lang?

A. Yes, sir.

Q. What is M. D. Anderson? Are you familiar with that facility?

A. Yes, sir.

Q. That's not a bunch of turnip truck guys

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out there, is it, Doctor?

A. It's an outstanding institution.

Q. Did they do a resection?

A. To the best of my knowledge, no.

Q. You don't think they did a resection of his lung?

A. No, sir. I know of no resection that they did at M. D. Anderson.

Q. Dr. Lang, you don't know that Mr. Nunnally was operated on in Houston, Texas?

A. Yes, he was. He was operated at Baylor University, not at M. D. Anderson, sir.

Q. Was he sent to M. D. Anderson, Doctor, not the actual facility he was operated on, but who did the work out there, who worked him up and followed him?

A. I don't know, sir. The records indicate that Methodist Hospital, Baylor University. If he was operated at M. D. Anderson, it's another operation. I've not seen a record of that. I don't know of nothing that he ever has been at M. D. Anderson from the records that I saw.

Q. Okay. Wherever he was treated in Houston, Texas, Doctor, was he resected?

A. Well, I'm sorry, you lost me. I mean, if

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you know of a second treatment that was instituted, I haven't seen it. I haven't seen those records. I know that he was resected at Methodist Hospital.

Q. Okay.

A. Which is a component of Baylor University.

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Q. Without regard, Doctor, to where the facility is, what hospital it's done in, he was resected, correct?
A. At -- to my knowledge.
Q. Yes, sir.
A. At Methodist Hospital at Baylor University, he was resected, yes, sir.
Q. And is a resection done for any kind of metastatic lesion?
A. Yes.
Q. You think that if somebody has metastatic lung cancer, they will do a resection?
A. Yes, sir, very frequently, and I refer you to specific articles, for example, "Skinner," that's 15-year-old. There are literally hundreds of articles that recommend resection, segmental resection of a solitary or multiple metastasis a menial to resection, of concomitant resection of tumor, the most commonly practiced procedure in the

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United States. And most certainly the procedure that would be practiced at M. D. Anderson had he been there.
Q. You think that would be the norm?
A. Yes, sir.
Q. If we thought this was a metastatic the lesion, we would resect it?
A. If you had a melt static resection, solitary or multiple that is a menial to resection of the lung, and the primary lesion can be resected, specifically, for example, renal cell carcinoma, clear cell carcinoma, that is the treatment of choice in the United States, in Europe, and in many parts of Asia. It is replete in the literature.
Q. And do you think that if anybody suspected it had pancreas as origin, they would do a resection of any kind, would they, Dr. Lang?
A. On the pancreas, they would not. No, sir.
Q. In fact, they seldom operate on the pancreas, itself, if it's involved, do they, Doctor?
A. There are specific operations.
Q. There is a procedure.
A. There are specific operations. They are classically designed operations on the carcinoma,

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the head of the pancreas. They are rarely used, because usually it's too advanced by the time you find it.
Q. And you found nothing in this record anywhere that any of these facilities ever considered any pancreatic lesion in him, did you, sir?
A. No, sir, but then, I haven't seen any records of M. D. Anderson. So if you have additional records, I haven't seen those, so I don't know.
Q. Now, this little red blood vessel you have drawn here, Dr. Lang --
A. Yes, sir.
Q. -- that you said you think has been pushed out of the way by this tumor in the pancreas, correct?

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A. Yes, sir.
Q. Do all our blood vessels just -- in every one of us, all 12, 14 jurors, whatever, does everybody's go just exactly like they're supposed to go, Doctor, all the time?
A. No, they can be variant. None of them, however, are curvaceous. They don't make bows and bends for no reason. If they have a bend in them,

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then there is a reason. And the reason is usually that there is a space occupied lesion or a mass there that forces them to bend.
Q. Anything at all that you told Mr. Ulmer and the jury earlier today that's any kind of cutting edge pathology that people in Memphis at the Methodist Hospital there shouldn't know about, Doctor?
A. Please repeat the question. I didn't understand it.
Q. Anything about your testimony and your explanation today that is so cutting edge and so intricate that the pathologist, board certified pathologist in Memphis, Tennessee, shouldn't be aware of it?
A. No, sir.
Q. How about in Houston, Texas?
A. No, sir.
Q. Should they be aware of everything you're saying?
A. I'm certain the pathologist there is an excellent pathologist, I'm sure.
Q. So they ought to be able to see the same size of the lesion you did?
A. I think so, sir.

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Q. What does "periphery" mean, Doctor?
A. Periphery is the outside of any given area.
Q. Well, on this chart of the lung here, you started pointing every time around here. And then you kind of went around like that. Is the periphery just on this side, or is it on this side, too?
A. The periphery is circumferential, sir, all the way around. For example, if you take an apple, to make it very simple. The edible part of the apple is the periphery. The core of the apple is what is left over, that's in the center. So the periphery is circumferentially around it.
Q. So this is periphery over here, and this is periphery over here?
A. Yes, sir, on the rim.
Q. It's not just on this outside, it's also over here?
A. No, sir, absolutely not.
Q. So I guess, Doctor, if we had a tumor that started out the size of a be-be or a marble, and it grows, do they generally grow in all directions, expand?
A. Generally, it does.
Q. They don't start at one edge and just the

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other edge runs out like this unless something is confining it and trapping it?

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A. Precisely, if it is confined from con side, like, for example, the thoracic cage, then obviously, unless it penetrates the thoracic cage, the bones, which is unlikely, it has to grow the other way, because it can't expand. It doesn't have any space.

Q. But if it does what they normally do, it would expand in every directions at once, just becomes a bigger ball, and a bigger ball, and a bigger ball?

A. Absolutely, that is correct.

Q. In this board here, number 478, Doctor.

A. Yes, sir.

Q. This white stuff is the tumor?

A. Yes, sir.

Q. From out here to over here?

A. No, a little bit less. You can see that there is lung cutting in.

Q. This is bone, spinal column or whatever through here.

JUDGE CARLSON: You need to go down, Doctor?

A. May I step down, sir? What you have here

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is the white stuff is tumor, but you can see that there's aerated lung coming in here. You see the shade of gray.

Q. (By Mr. Merkel) I see a little down here. What about up here is where I'm looking?

A. Up here it is overlapping, because you have a very large mass.

Q. This tumor here, Doctor, that we see in white stuff, that is tumor?

A. Right up here, this is tumor, yes, sir.

Q. And it stretches all the way from the rib cage to the center part of the body, the spine, whatever you want to call it?

A. Well, not quite. If you look, as you can classically see, this area is lighter, okay. So this area of lung here, moreover, I have showed that to you on the CT cut. You can see the area of lung coming in here. There is tumor that is very large and overlapping. And this is an intermediate effect. So if you want to look at this, we can look at the CT cut.

Q. All I'm asking you, Doctor, on this one, is this white stuff from here to here tumor?

A. This is homogenous tumor. Here it is a combination.

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Q. I didn't ask you here, Doctor, right here.

MR. ULMER: Your Honor.

Q. From there to there, is that tumor.

JUDGE CARLSON: Hold it. We've got three people talking at one sometime.

MR. ULMER: That was my objection is that Mr. Merkel continues to talk over the witness, and we object to that, and also, it's Dr. Lang, L-A-N-G.

MR. MERKEL: I'm sorry, Your Honor. They furnished him to us as Dr. Land.

Q. (By Mr. Merkel) I'm sorry, I haven't meant to insult you by that, Doctor. They gave us

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your name L-A-N-D.
JUDGE CARLSON: Let's have question and response one at a time, okay.
A. The question as I understand it is this homogenous tumor. The answer is no. Because this area is dense, this area is less dense, so you have lung shining through partially, and you get what is called a partial volume. In order to the clarify that and not confuse you or confuse us. That's why we did a CT cut, and on the CT cut, we can see that there is normal lung on this. That's the reason for the CT. Otherwise both you and I could be confused

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and could assume that the tumor extends all the way to the side.
Q. (By Mr. Merkel) My question, quite simply, again, Doctor, not about homogenous, not about anything else, is white stuff from here to here indicative of tumor, yes or no, please?
A. The answer is it is partially indicative, since it is less dense, it is not so indicative. If you have a composite. All I can tell you is gray, this area is grayish, this area is whitish, you know.
Q. And if it's less dense, then the jury can see it's less dense just like you and I can.
A. Correct.
Q. Thank you. Doctor, is it your considered opinion that everything that Methodist did with regard to diagnosis and treatment of this patient was wrong?
A. No.
Q. If I wanted you to appear as an expert for me in a malpractice case against them for misdiagnosing his sarcoma and treating it as a bronchogenic carcinoma, would you do it?
A. No, sir, I don't think it was all wrong. They had an enormous tumor burden, and they

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instituted treatment because of the tumor burden. I think there was absolutely nothing wrong that they did. If anything, they could have expanded on their diagnostic efforts. I am not certain it would have made any difference whatsoever.
Because a carcinoma of the pancreas, he would not have survived. I don't think anybody did him any wrong. Neither the first institution nor did Baylor University did him any wrong in Houston. And if he was at M. D. Anderson and something was done there as you allege, which I don't know, I don't think they did anything wrong to him.
Q. You disagree with their diagnosis, you say it's not bronchogenic carcinoma?
A. I do not think it's bronchogenic carcinoma, no.
Q. You disagree with their treatment, because they didn't treat the him for sarcoma?
A. No, I don't. I think it was a treatment option that was probably not optimal. But didn't do him any harm and may have prolonged his life to some degree. Possibly chemotherapy might have been slightly superior, but I think as matters stand the poor gentleman was doomed one way or the other.

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They did the best in both institutions and possibly
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also at the Anderson, if a third resection was carried out. I don't see anything wrong with any of the treating physicians. They did their best under the circumstances.
Q. They used the wrong diagnosis and the wrong treatment, but it just didn't make any difference?
A. Well, sir, there are unfortunately certain stages of diseases, where no matter what we do, we cannot save the patient. And under these circumstances, our attempts are to the ameliorate symptomatology. It didn't really make that much difference. There would be some response to radiation therapy. They elected radiation therapy first. The second group elected chemotherapy, and I think that was a good choice. I don't think either group was at fault.
MR. MERKEL: Nothing further, Your Honor.
JUDGE CARLSON: Redirect?
MR. ULMER: Just a few questions, Your Honor.
REDIRECT EXAMINATION BY MR. ULMER:
Q. The large tumor that was in the right upper lobe, you have described it as a sarcoma.
A. Yes, sir.
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Q. And not a squamous cell carcinoma.
A. Yes, sir.
Q. And Mr. Merkel, I think, was confused about -- is it your contention that the sarcoma metastasized from outside the lung to there, or did it originate in the lung?
A. Sarcomas are blood borne tumors. They could come, from for example, osteogenetic sarcoma. They could come from the bone. They could originate in the interstitial tissues of the lung. They could come from cartilage. It doesn't make much difference. They are sarcomatous legions spread by the bloodstream.
Q. The metastasis you talked about, it came, I believe you gave the jury your opinion it came from the pancreas to the right middle lobe?
A. Most likely.
Q. Is that the metastasis you were talking about as opposed to the large tumor in the upper lobe?
A. Yes, sir.
Q. Is it your opinion or not there was a metastasis from the pancreas that went to the right middle lobe?
A. Yes, sir.
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Q. And is it your opinion or not that the large tumor in the right upper lobe was a sarcoma?
A. Yes, sir, it is.
Q. How certain and how firm are you in that opinion?
A. By size of the tumor, by lack of necrosis in the tumor, by the appearance of the rim of the tumor and by the fact that the patient was alive, it was most likely a sarcoma.

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Q. All right, sir. Now, Mr. Merkel asked you if you knew that the radiologist, Dr. Alpert, out in Houston, Texas, had diagnosed this as squamous cell carcinoma. Tell the jury what the radiologist -- I mean the pathologist in Houston determined the cell type to be.
A. Well, to the best of my knowledge, she determined it that the one that came from the middle lobe was clear cell, and the other one was most likely, again, a sarcoma.
Q. Let me ask you this specifically, did -- and you may not know this. And if you don't, that's okay. Did the pathologist, Dr. Alpert, in Houston, actually get the fine needle aspirant slides from Memphis and look at those slides?
A. To be honest, I don't know.

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Q. You don't know.
A. -- on what basis she made the diagnosis.
Q. Do you know -- well, if you don't know that, you wouldn't know the next question. With respect to the treatment provided by Memphis, did Memphis treat this as an operable tumor or not?
A. No, they treated it as an inoperable tumor.
Q. All right. Do you -- do you know the circumstances that took Joe Nunnally from Memphis where they would not operate to Houston, Texas, where they did operate?
A. Well, I presume he did what most patients do, and very reasonably so, he wanted a second opinion. And Houston has a very good reputation, so he went to Houston to get a second opinion.
Q. Is it unusual for one institution to say that it's inoperable and we won't operate, and yet a second institution, second hospital, follow up and do the surgery. Is that unusual or not unusual?
A. It's really not that unusual. Because for one reason, when you get into more extensive surgery, one or the other hospital may be more prepared to do it and will be more attuned to do it. The other thing is any procedure, irregardless of

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what is done, is not done on the dogma of the physician, but is done on the request of the patient.
You tell the patient what you think could be done. And then the patient decides whether he wants to have it done or not, and it is the patient's perfect right to decline it or request something. It is his privilege to determine the treatment, not the physician determines the treatment.
Q. Just a final thing. And tell the jury if, in your opinion, based on all the evidence that you've seen, and you've studied and you've considered, based on all the evidence, it is your opinion, to a reasonable degree of medical certainty, that the large tumor that was located in the right below Joe Nunnally was a sarcomatous lesion?
A. Yes.
Q. And is a sarcomatous lesion associated

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with smoking?
A. Not to my knowledge.
Q. All right. Final thing. The metastasis that you've described in the middle lobe, the coin shaped or --

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A. Cannon ball.
Q. -- cannon ball shaped metastasis that the jury has seen on CT in the right middle lobe, do you have an opinion based on a reasonable degree of medical certainty, do you have an opinion whether that metastasis came from the lung or from outside the lung?
A. From the outside the lung.
Q. Where is your opinion?
A. From the evidence we have, we can only incriminate one area, and that would be the tail of the pancreas.
Q. All right, sir. And you were describing to Mr. Merkel, you know, unfortunately the doctors don't get involved until it's, in effect, too late. What would be the likely outcome for the patient of a sarcomatous lesion this large and in combination with a metastasis from the pancreas?
A. I think he is unfortunately doomed to die.
MR. ULMER: Thank you, Your Honor. We have nothing further.
JUDGE CARLSON: Is Dr. Lang finally released?
MR. ULMER: Yes, sir.

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JUDGE CARLSON: Thank you, Doctor. You're released. I know you're ready for a break. Let me confer with counsel before we do that.
(Off-the-record bench conference.)
JUDGE CARLSON: All right. Ladies and gentlemen, what I was trying to determine, since -- based on the lateness of the hour, as to who the next witness might be and how long the next witness will take. I don't think you want to hear how long it might take, but long enough to I know you don't want to stay here into the evening to hear the next witness.
I mean, it would take too long, and you've put in a full day, so instead of working you well into Friday night, I'm not going to do that. I think I would be breaking my promise to you if I said we'd keep on a schedule roughly 8:30 to 5:00 o'clock everyday as best I could, recognizing we might stop a little early or a little past 5:00 if we could get through with a witness. But this next witness would not fall into that category as far as getting through, you know, a little after 5:00.
So let's go ahead and stop here for the weekend, and we'll move forward, and if we are off schedule, at this point, I don't think we would be

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that far off schedule, still try to go ahead and move forward to a conclusion next week. Hopefully the early part, middle part of next week as far as getting the case to you.
So let's go ahead and stop here for the

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weekend. The only thing I need to remind you of, of course, is please not discuss the case, make any effort to gain any outside information, read any news articles, save that until after the trial. Hope y'all have a good weekend, and we'll see you Monday morning at 8:30.

(Jury exits courtroom.)

JUDGE CARLSON: Let's go ahead and take a short break, and we'll go forward in just a few minutes.

(A short break was taken.)

(Exhibits 474, 477, 478, 479, 480, 481, 482, 484, 486 and AN-001128 marked for identification and entered into evidence.)

JUDGE CARLSON: I understand that the next witness that will be called which will be Monday morning, there's to be objections to be taken up on that testimony?

MR. LISTON: Yes, sir. For the record, we'll announce that the identity of that witness is

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Dr. George Seiden.

JUDGE CARLSON: All right, sir.

MR. MERKEL: Your Honor, Dr. Seiden, we have been furnished expert interrogatory response with regard to him. He is apparently a psychiatrist and going to testify based on his exhibits about a whole lot of different definitions of addiction, and habituation and such things as that which is not really the subject matter of our problem. The generic stuff is not.

They state, also, that Dr. Seiden will testify regarding the evidence of Mr. Nunnally's personality, intelligence, ability to discern messages, to make decisions and to follow through on his decisions. He will also address his awareness of risks of his personal life-style choices. Dr. Seiden will demonstrate throughout his life Mr. Nunnally had the ability to control his behaviors, make reasoned decisions, accept responsibility for his decisions and change his behavior to the extent he chose to.

And then the grounds for that is he bases his opinion and testimony on his education, training and experience, his review of the existing evidence, including Mr. Nunnally's medical records,

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depositions and other evidence in this proceeding, and his review of other pertinent scientific literature.

And it's that last part that I just read that we -- and I understand we don't have a -- Dalbert does not apply directly in Mississippi, but I think the Court still has a gate keeping function to keep patently invalid expertise from being presented to the jury. And I would like to have the witness tendered whatever it is he wants to say in this regard, Your Honor, outside the presence of the jury so the Court can rule on it.

I don't think there's any way possible a psychiatrist can tell us what a person who he has never met or talked to or seen. And all he has are squibs from memories of friends 30, 35, 40 years in

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the past who say I think he knew this or I think he understood that because I did and things like that. I mean, that just to me as patently ridiculous that a psychiatrist would base a supposed learned opinion on that type of criteria. If he's something else, then I stand to be corrected.

But they've given us some copies of the squibs that he's going to rely on, and some of the more important ones are "Is there any doubt in your

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mind Joe knew about the risks that were being reported about cigarette smoking?" Answer: "I think he knew. I think we all knew, knew the risks." "Was Joe Nunnally aware of the health risks?" "I think he would have been aware of it as most of us are." And those kind of answers are apparently what he's basing his testimony on, Your Honor, and that's just not the subject of a proper psychological or psychiatric formation of a proper psychiatric opinion, I would say.

JUDGE CARLSON: Mr. Liston? Do you have a response?

MR. LISTON: Yes, sir, Your Honor. Dr. Seiden is a psychiatrist, and he specializes in the fields of dependency, substance abuse, and those fields. And he will offer an opinion based upon that information that has been brought forward either by depositions that he's read of the witnesses in this case, or testimony that's been given in this case concerning those issues of whether or not Mr. Nunnally had the ability to stop smoking and whether he could smoke.

And if fact -- and as I take it this is the really the graviment of Mr. Merkel's objection is he can't testify because he never saw

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Mr. Nunnally, and he's basing it on what his friends and relatives said about it, and that's a crazy way, as Charlie, I think, is saying to present that. But Your Honor, it isn't.

We do it everyday in the courts of Mississippi. In will contest test cases, psychiatrists take the stand, and based on what people say about the person who left the will, these psychiatrists have been accepted by the Court as experts to testify whether the person had testamentary capacity based on his acts, and if he knew what he was doing and recognized his surroundings and those things. So it's certainly not anything new that -- a methodology that the Dr. Seiden is going to the utilize in this case to reach his opinion.

There are many instances that this happens in. In insurance cases where there's a death and the insurance company claims that the insured committed suicide. And the same process is done by psychiatrists for both sides in cases like that, that are accepted as experts. They give opinions based on what the friends and relatives of people that knew these people saw.

And they'd get on the witness stand, and

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they'd testify, and have never seen this person,

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never knew the person in their lifetime. And there are just numeral instances -- numerous instances where that type testimony is allowed. And it sort of surprises me that the Plaintiff has an objection to this. But I think the proper way to do this, if the Court has any doubts at all, is Monday the first thing that we're going to do is put Dr. Seiden on the witness stand and go through his qualifications to do this. And we feel sure that after that examination that Mr. Merkel can voir dire him at that time and make the objection at the correct time. That that's the way that we should proceed with this.

I wouldn't ask the Court right now to make the decision to say yes, he can testify to that. I don't think that's fair to the Court to do that. I think you've got to hear his qualifications, his experience and his training and what he's done with his professional life to qualify him to give these opinions, which will be of aid to the jury in this case.

JUDGE CARLSON: Anything further?

MR. MERKEL: Basically, Your Honor, it's not whether he's a qualified psychiatrist that I'm

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challenging, and it's not that under some circumstances he might not be able to get enough information in some fashion to do it. But when he's relying on statements like did he enjoy smoking? Answer: "Obviously, he did." "Did he tell you -- was he one of those people that smoked because he liked to smoke?" Answer, "He enjoyed smoking. It gives you something to do with your hands, I guess."

And you heard Mr. Fischer questioned who opined about several things, and then he admitted he didn't have any idea what he was talking about, he was guessing about certain things. And that's what we've got, and besides that, about half of the data that's been given to us as forming the basis of his opinion isn't in this record. Witnesses have come, gone, testified, and they didn't say the things that are in here. And obviously, that would have to be culled out, too, not something that was read in some deposition that is not before this jury.

MR. LISTON: Well, that's not right, either, Your Honor. Under the expert rules of evidence, a witness can base his opinion on matters that were related to him extra judicial proceeding statements. Certainly he ought to be able to read a deposition that was taken at the case, in that very

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same case where that witness was under oath. And the test is whether or not professionals in that field ordinarily rely on that source of information to make day-to-day decisions in their practice, and we meet that. It doesn't have to be from the witness's stand in here.

MR. MERKEL: If it was so unreliable, Your Honor, that it couldn't be gotten to the witness stand, it should not be relied on by a witness to tell the jury that I'm relying on something that the jury hasn't heard, and if they'd have tried to get it in, they wouldn't have been

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able to get it in such as assumptions and guesswork, and gee, I don't know, but if you wanted me to guess, I'll say probably he did or things like that. And that's the type -- type stuff we're looking at in most of this. And if it hadn't come in at all even to that extent, then it shouldn't be reliable enough for him to base some off-the-wall opinion on.

MR. LISTON: I submit that goes to the weight and not the admissibility.

JUDGE CARLSON: I think the question, the best way to handle this would be to put the witness on the stand Monday morning and go through it in the normal procedure. Have the Defendant attempt to

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qualify him, voir dire him, go from there. I think under Rule 703, it states clearly that facts and data relied on totally or in part by the expert witness need not be admissible into evidence. I think clearly under Rule 702 and 703, that would be the appropriate way to do it. Anything further of this Court?

MR. ULMER: I'm afraid to bring it up, Your Honor, but I don't think it will take long. We have previously provided to the Court and counsel opposite stipulations from the pretrial order that we want to read, and I understand there's no objection to that. We have provided to the Court and to counsel opposite responses to requests for admission that we want to read. And Mr. Merkel has indicated he objects to some of these requests for admissions, and I'll give you an example.

The first request for admission that we want to read to the jury, and there are a number of them, "Admit you have no evidence or knowledge that Plaintiffs' decedent Nunnally ever saw, read or had read to him any statement by R. J. Reynolds that cigarette smoking was healthy for you."

We want to read that to the jury because it has been made relevant by the statements and the

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evidence that's been put in by the Plaintiff. The Plaintiff has put before the jury that through advertisements, through testimony by Burns, and through other means that he did hear things that were put forth by R. J. Reynolds, and so we're perfectly entitled -- if we had a witness on the stand, we could ask that you have no evidence that Joe Nunnally ever heard or saw these things.

So his objection is to the way it's framed, that there is no evidence. But the fact that the Plaintiff has no evidence is a very important fact when they have made that issue and made that contingent here. So Your Honor, we would like to get that resolved now so that when the jury does get back here, we could proceed to read the requests for admissions stipulations that I previously served counsel with, and with some interrogatories as well.

Now, I don't know of any objections to anything except for the request for admissions that are framed along the lines of you have no evidence or knowledge.

JUDGE CARLSON: Let me make sure just for

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the record that we get clear, these were tendered to me previously, these reviewing, when I'm using the

last three numbers, 48968, there's no objection to that?

MR. MERKEL: No objection, Your Honor, about the stipulations, that part of the pretrial order.

JUDGE CARLSON: Right.

MR. MERKEL: These are all those things that they tried to include in the pretrial order and Your Honor ruled were not appropriate for inclusion in the pretrial order. Now they're trying to get them in by trying to read them in as some admission. Our position is they are not facts. They're not facts for a jury. They never were facts. They were not even properly a subject for request for admission, because they were not a fact.

JUDGE CARLSON: Time out. Make sure we're clear. 489, stipulations and admissions.

MR. MERKEL: May I come up, Your Honor, and look? I don't have it. I didn't know this was coming up, and I don't know where mine is.

MR. ULMER: I have an extra set if you'd like it.

MR. MERKEL: We don't have any problem with any of these, Your Honor.

JUDGE CARLSON: And then 492 was

interrogatory response to what is 493. I'm saving the best for last. I know where the objections are. That's what I'm trying to get these other dealt with.

MR. MERKEL: We don't have any problem with the interrogatories, our answers, such as they were, being published.

JUDGE CARLSON: Okay. And 493.

MR. MERKEL: As far as the state and time when they were done the, there's no problem with any of that, no, sir. Now, it's all these other things.

JUDGE CARLSON: 494 and -- let me just make a few comments on this. I guess I recall the story that was told on Judge Cady at some point when he was sitting there all intent listening to testimony, all of a sudden the question was asked, and he's on the bench, and he says, "I object."

And he thinks for a second, he says, "Objection sustained." It's almost like I have to say I kind of object to some of this, but I know we dealt with this pretrial. And a lot of time spent on -- in going through and what had been admitted or not admitted, and what responses were complete or not complete or inconsistent. I recall the Court entered orders and directed the Plaintiff to amend

its answer -- answers to requests for admissions.

Let me tell you where I see all this going. And I have to say -- and maybe memory fails me. But I don't I don't ever recall, and I may have said this along the way, all these years on dealing with requests for admissions, I don't ever recall requests for admissions being admit that you have no evidence of this or admit that you have no evidence

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of that. It's always admit this fact or admit this. You know, is it a fact or not. I think that's the purpose of the rule, Rule 36, to get all this undisputed stuff out of the way, not to waste time proving a fact that's not in dispute.

So we get into admit that you have no evidence, and it almost puts the Plaintiff in the position of proving the negative where you'd have to call in the world population to prove the negative.

MR. MERKEL: That's exactly my point, Your Honor.

JUDGE CARLSON: Also, it comes to light, especially over a period of time when I've been reading the jury instructions. And when you get to admit that you have no evidence of this or that. And then the Defendant, and it will be interesting seeing any authority for it, but when the Defendant

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proposes instruction D-5 that says, "Since Plaintiff has the burden of proof, she is required to produce the most explicit, direct and satisfactory proof available with respect to the cause of Joe Nunnally's cancer and death, or the presumption that if more satisfactory evidence had been given, it would have been detrimental to her case.

If you believe from the evidence that more explicit, direct and satisfactory evidence was available to the Plaintiff, then that than that which was produced, then you are justified in presuming that such evidence had been produced by the Plaintiff, it would have been adverse to the Plaintiffs' claim that smoking caused Joe Nunnally's cancer and death." Y'all may be able to prove me wrong, but I thought this instruction that -- I know I've given many times in years past, that somewhere along the way, the Supreme Court has now condemned this instruction. Am I correct?

MR. MERKEL: I think you are, Your Honor.

MR. ULMER: Charlie is of right mind to agree with the Court right now, Your Honor, which is real unusual, I might add. I hadn't seen a lot of that up to this point.

JUDGE CARLSON: Classic example. Used to

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happen in -- I know Bill doing a lot of Plaintiffs work can recall, and from the defense side, too, the defense would admit the treating physician that the Plaintiff didn't call. That old instruction if the Plaintiff didn't call their own doctor, if called you can presume it would have been detrimental to her case. That used to have been given all the time. I really believe that instruction has been condemned.

MR. MERKEL: It went out the window, Your Honor, when the privilege was waived as to medical conditions that a person was putting at issue in the lawsuit. The Court said the reasoning or rationale behind it is, either side can bring that evidence. So there's no indication by the Plaintiff not bringing the doctor that it's adverse to him, because the Defendant's equally able to bring the doctor.

JUDGE CARLSON: That's where I see we're

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going with all these requests for admissions. And if the Court permitted these to be read to the jury, of course, this instruction would be submitted. And I can't imagine of a jury getting more confused over, you know, what if -- what if all this evidence may have been out there, if it --

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MR. MERKEL: And the rule --

MR. ULMER: If I could say one thing. Charlie has had the floor all the time.

MR. MERKEL: I didn't know I had said anything, Mike.

MR. ULMER: You've had the floor more than you deserve.

JUDGE CARLSON: Let me hear Mr. Ulmer.

MR. ULMER: I'm not here to defend jury instruction number 5. I don't really know. I don't --

MR. MERKEL: He's not the lawyer for that one.

MR. ULMER: It may be wrong. But I'll tell you this, these requests for admissions are not wrong for a whole bunch of reasons. But the first reason was when we were arching about the pretrial the order, they didn't want them in the pretrial order. They said they don't go in the pretrial order. I have the transcript where Mr. Merkel says if he want to read them, let them read them in their case. But the Court observed I'm not going to give you the hammer of putting this in the pretrial the order. I think I remember that correctly, and I think the transcript will bear that out.

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Second thing, much more substantive than that, if the Plaintiff hadn't tried the case the way they tried the case, with innuendo, about things that are not in the case, it would be totally unnecessary to tell the jury what they don't have any evidence of. That's the reason for these, and why I think under these unusual circumstances, and I agree with the Court, it is oddly phrased. But under these circumstances we have here, it's unfair to let them throw a stinking, rotten fish over in that box and say we can't do anything about it.

You can't come back and say Plaintiff you tried the case on three weeks what Nunnally may have known from R. J. Reynolds, but they've admitted they don't have any evidence at all of that. That would be unfair. Your Honor, I hope I wasn't disrespectful about getting the floor from Mr. Merkel. I positively meant none towards you, maybe only a little bit towards Charlie. But not much, I can assure you.

JUDGE CARLSON: Okay.

MR. ULMER: I think these are entirely fair under the circumstances here.

MR. MERKEL: Your Honor, they're improper. They're entirely improper, because they

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are not facts. They're a statement as to the state of the evidence on a certain day six months ago, or nine months ago or a year ago or whatever date is on the things.

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Any evidence that has gone before that jury, whether I got it on cross examination, they put it on an or I put it on is before that jury. And if one of these stupid things says that nine months ago we didn't have any evidence that this, that or the other happens, and now there's been three witnesses get on the stand and say something that meets evidence in that regard, it would just be totally ridiculous to read that. And it is not a fact.

The only thing that could have anything to do with would be going towards a summary judgment if they asked us do you have anything that you haven't seen, or we haven't been given in other discovery, admit that there is nothing else going to this issue. And we admitted there was nothing else, they could bring before Your Honor, then, a motion for summary judgment on whatever that was. But that is not evidence to go to the jury. The jury's the judge of what the evidence is, circumstances, direct, cross examined evidence put on by them or by

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us.

And what we could have proven five months or 10 months ago is not what's relevant in this trial. It's what that jury has heard. And what we could do then, some of those things, we have no burden to do anything on. Most of them are not even our issues. We could care less at that point in time whether we had somebody that was going to say Joe Nunnally went to somebody to get a prescription for nicotine gum. That's not our issue. That's their issue, that he should have somehow quit smoking.

So we didn't have any evidence about it. We didn't develop anything about it. We were under no burden to develop anything about it. If they want to put on evidence of something, if they want to prove the negative, that's up to them. But they can't do it with us, because it's not our issue. But mainly, they're just not facts.

MR. DAVID: I have --

MR. MERKEL: The discovery statutes, rules dealing with requests for admission specifically point to factual matters, historical facts that are not in dispute. And the state of evidence is not a historical fact, Your Honor.

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MR. DAVID: May I have a minute?

JUDGE CARLSON: Mr. David.

MR. DAVID: As the author of those stupid things, I perhaps -- I think, Your Honor, if they admit that they have no evidence of a certain fact, then -- they think they cannot deny the fact. So it seems to me that they -- that they then admit -- essentially admit the fact. So that's why they're drafted that way. And -- and I think they're entirely appropriate drafted that way. But then again, I would say that since I drafted them.

MR. ULMER: Your Honor, Charlie is -- is not correct. I started to say wrong, but I figured that would be too impolite. Rule 36 says "That a party may serve on any other party written request

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for admission of the truth of any matter within the scope of Rule 26 set forth in requests that relate to statements or opinions of fact or the application of lawful to fact, including the genuine documents." I don't think Rule 36 is restricted as the Court suggested. But again, I've had my say, and if the Court's ruling -- it's what the ruling is.

JUDGE CARLSON: I feel, you know, very strongly that -- the way this needs to come about. The ultimate filter, of course, all the Rules of

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Evidence we have and Civil Rules of Procedure, and the ultimate filter through all of this -- all of this has to flow through would be Rule 403. You know, although relevant evidence may be excluded, probative value substantially outweighed by the danger of unfair prejudice or confusion of the issues or to mislead the jury.

I think that's what would happen here. Whatever probative value this might have would be substantially outweighed by danger of unfair prejudice, confusion, misleading the jury. So if I marked these correctly, I believe -- let me go at it from the standpoint of what would not be excluded. It appears that request number 37 in the response would be appropriate to read, as well as request number 121 and request number 134. And then the others would be excluded if I -- I think that would be the appropriate way to deal with it.

MR. ULMER: Thank you, Your Honor. Could I have marked for identification purposes the partial document that was tendered to the Court?

JUDGE CARLSON: Yes.

MR. ULMER: In fact, there were two.

JUDGE CARLSON: I'm sorry, right. I didn't do the other one. The one I just referred to

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was 490, and 491 appears -- let me make sure here. Like request number 108 would be appropriate in the response if I've read that correctly, and the other two would be excluded.

MR. ULMER: And we will tender, for the record, 490 and 491 for identification purposes only, Your Honor.

JUDGE CARLSON: Let them be marked for the record.

(Exhibits 490 and 491 marked for identification.)

MR. ULMER: Thank you very much, Your Honor.

JUDGE CARLSON: Anything further at this point?

MR. MERKEL: Have a good weekend, Your Honor.

JUDGE CARLSON: We'll stand in recess until 8:30 Monday morning.

(Time Noted: 4:40 p.m.)

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